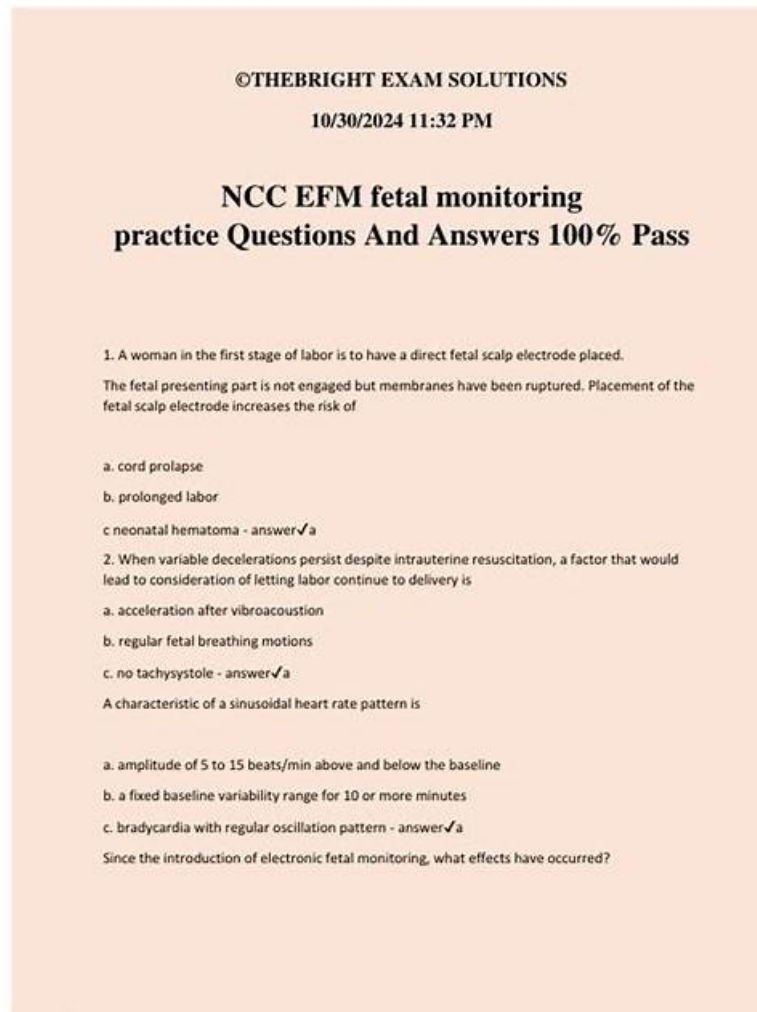


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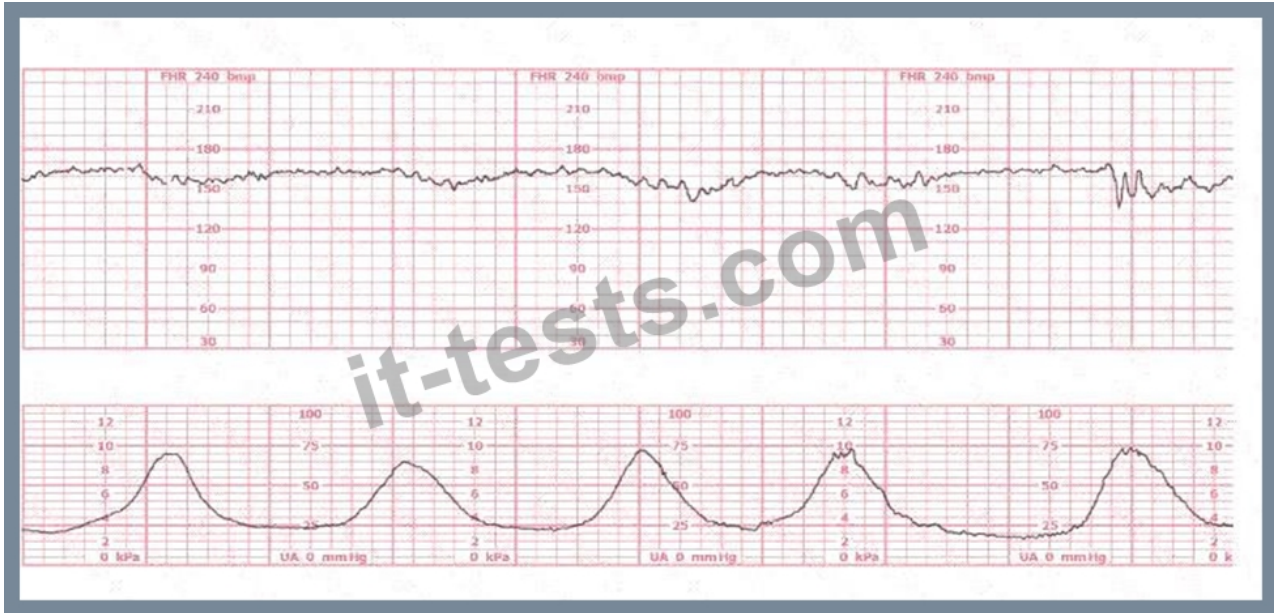
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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q22-Q27):

NEW QUESTION # 22

The tracing shown is a:



- A. Category III
- B. Category I
- C. Category II

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

The tracing demonstrates:

- * Baseline: approx. 140 bpm
- * Variability: minimal-to-moderate (fluctuating but not consistently moderate)
- * Decelerations: shallow variable decelerations
- * Accelerations: not consistently present

According to NICHD/NCC definitions:

Category I requires ALL of the following:

- * Baseline 110-160
- * Moderate variability
- * No late or variable decelerations
- * Early decels and accelerations may be present

This tracing does not have consistently moderate variability and does have variable decelerations, so it is not Category I.

Category III requires ANY of the following:

- * Absent variability with recurrent late decels
- * Absent variability with recurrent variable decels
- * Absent variability with bradycardia
- * Sinusoidal pattern

This tracing does not show absent variability, bradycardia, or recurrent significant lates.

Category II includes:

- * Minimal variability
- * Absence of accelerations
- * Variable decelerations
- * Tracings not clearly Category I or III

This strip fits Category II exactly due to minimal variability + intermittent variable decelerations.

Thus, the correct classification is Category II.

References: NCC C-EFM Candidate Guide; NICHD Three-Tier Interpretation System; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan; Miller; Simpson & Creehan.

NEW QUESTION # 23

Uterine contraction intensity is manually measured by degree of uterine:

- A. Muscle strength
- **B. Indentation**
- C. Pain

Answer: B

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Equipment Concepts:

When using external tocodynamometry, uterine contraction intensity cannot be measured in mmHg. It is assessed manually, using palpation. NCC and AWHONN teach:

- * Contraction intensity is estimated by palpating the fundus during a contraction.
- * The degree of firmness versus indentation determines intensity:
- * Mild # uterus easily indented
- * Moderate # firm, difficult to indent
- * Strong # rigid, cannot be indented

Why the incorrect answers are wrong:

- * B. Muscle strength - Not measurable by external or manual exam
- * C. Pain - Not a reliable indicator; pain perception varies widely and does not correlate with uterine intensity.

Thus, the correct manual measurement is done through uterine indentation, making A correct.

References: NCC C-EFM Candidate Guide; AWHONN Principles & Practices; Menihan EFM; Miller's Pocket Guide; Simpson & Creehan.

NEW QUESTION # 24

In the event of recurrent variable decelerations with thick meconium, amnioinfusion is recommended to:

- A. Dilute thick meconium
- B. Restore uterine blood flow
- **C. Treat oligohydramnios**

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

Amnioinfusion is considered an intrauterine resuscitative intervention used specifically for recurrent variable decelerations caused by cord compression. NCC, AWHONN, Miller, and Menihan consistently teach that variables occur when the umbilical cord becomes compressed, reducing fetal oxygenation. When oligohydramnios or decreased amniotic fluid volume is present, the cord is more vulnerable to compression.

Why amnioinfusion is used:

Amnioinfusion works by:

Increasing intraamniotic fluid volume

Reducing umbilical cord compression

Decreasing the frequency and severity of variable decelerations

This directly targets the pathophysiology behind recurrent variables.

Why the other options are incorrect:

A). Dilute thick meconium - NOT supported by NCC

Historically, amnioinfusion was studied for meconium dilution, but major organizations-including NCC- aligned sources-state that amnioinfusion is NOT recommended for the sole purpose of diluting meconium. It does not reduce meconium aspiration syndrome and is no longer indicated for that purpose.

B). Restore uterine blood flow - NOT accurate

Uterine blood flow is addressed through maternal positioning, fluid bolus, reducing uterine tachysystole, and minimizing vasoconstriction-not via amnioinfusion. Amnioinfusion does not physiologically affect uterine perfusion.

C). Treat oligohydramnios - CORRECT

Recurrent variables with thick meconium often occur in the setting of low fluid, which worsens cord compression.

NCC-recommended indications include:

Recurrent variable decelerations unresponsive to repositioning

Suspected or confirmed oligohydramnios

Thick meconium may be associated with low fluid, but the purpose of amnioinfusion is to alleviate cord compression by restoring fluid volume, not to dilute the meconium.

Thus, the correct answer is C. Treat oligohydramnios.

References:

NCC C-EFM Candidate Guide (2025); NCC Content Outline; AWHONN Fetal Heart Monitoring Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 25

During amnioinfusion, the infusion should be stopped periodically to assess changes in:

- A. Patient pain level
- B. Contraction pattern
- C. Baseline uterine pressure

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

During amnioinfusion, NCC emphasizes monitoring for uterine overdistention, which can lead to uterine hypertonus, uterine rupture, or placental separation. The primary way to evaluate overdistention is by measuring baseline uterine pressure via IUPC.

* Rising resting tone (>20-25 mmHg) indicates accumulating fluid and risk.

* Stopping the infusion intermittently allows recalibration and assessment of uterine baseline pressure.

* Contraction pattern (option B) is important but not the primary safety parameter.

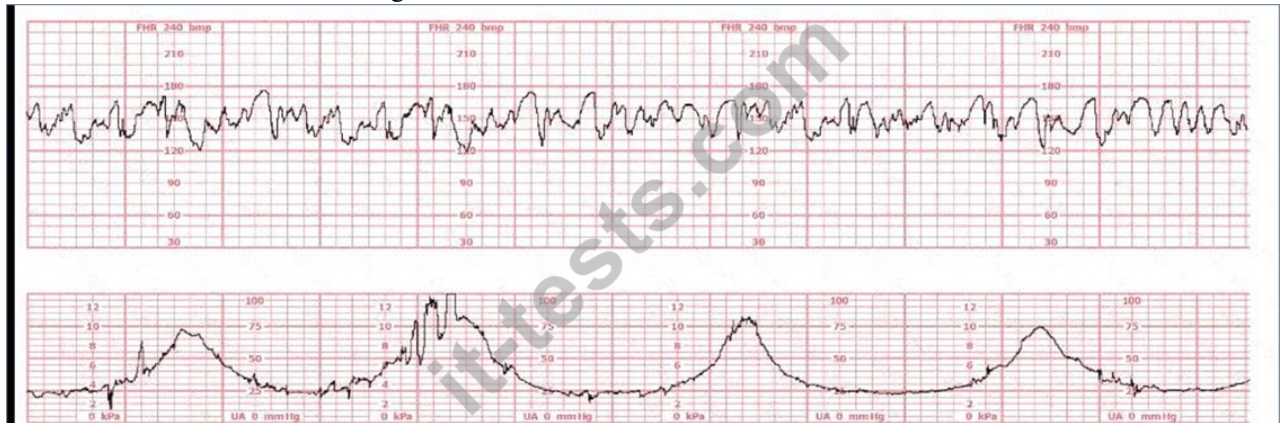
* Pain (option C) is nonspecific and not a reliable indicator of uterine overdistention.

Thus, the infusion is stopped to assess baseline uterine pressure.

References: NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring.

NEW QUESTION # 26

The baseline fetal heart rate in this tracing is:



- A. Indeterminate
- B. Tachycardia
- C. 155 beats per minute

Answer: B

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

On the tracing:

* FHR consistently ranges 170-185 bpm.

* Variability remains present, confirming adequate signal.

* This pattern persists for the required minimum 10-minute baseline window.

NICHD/NCC define fetal tachycardia as:

* Baseline > 160 bpm for at least 10 minutes

Because the FHR is well above 160 for the whole reviewable period, the baseline is tachycardic.

Why the other answers are incorrect:

* A. 155 bpm - Too low; FHR visually averages well above this.

* B. Indeterminate - Not applicable; variability is clear and the tracing meets the #10-minute rule.

Correct answer: C. Tachycardia

References: NICHD Definitions; NCC C-EFM Candidate Guide; AWHONN; Miller; Menihan.

NEW QUESTION # 27

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