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### NCC Certified - Electronic Fetal Monitoring Sample Questions (Q40-Q45):

#### NEW QUESTION # 40

Fetal supraventricular tachycardia will often appear on the monitor as

- A. the same rate as the maternal pulse
- B. artifact
- C. half the actual rate

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources NCC-recommended fetal assessment texts emphasize that external Doppler ultrasound may undercount very rapid fetal arrhythmias such as fetal supraventricular tachycardia (SVT). Because Doppler detects mechanical motion rather than electrical activity, the device may record only every other cardiac contraction

, a phenomenon known as "half-counting."

Menihan's Electronic Fetal Monitoring explains that with SVT-often exceeding 200 to 260 bpm-the monitor "may display a fetal

heart rate at approximately half the true atrial rate." AWHONN teaching materials affirm that rapid, regular tachyarrhythmias may appear deceptively slower on the external monitor due to Doppler under-sampling. Simpson & Creehan note that half-counting is a recognized technical limitation and may cause clinicians to miss true tachyarrhythmias if internal monitoring is not applied. In contrast, artifact displays irregular, inconsistent, and non-physiologic deflections. Matching the maternal pulse suggests maternal heart rate misinterpretation, not SVT.

Miller's Pocket Guide also highlights that half-counting is "commonly seen in fetal SVT when using external Doppler due to failure to detect each rapid contraction." Therefore, fetal SVT most commonly appears as half the actual rate on an external fetal monitor.

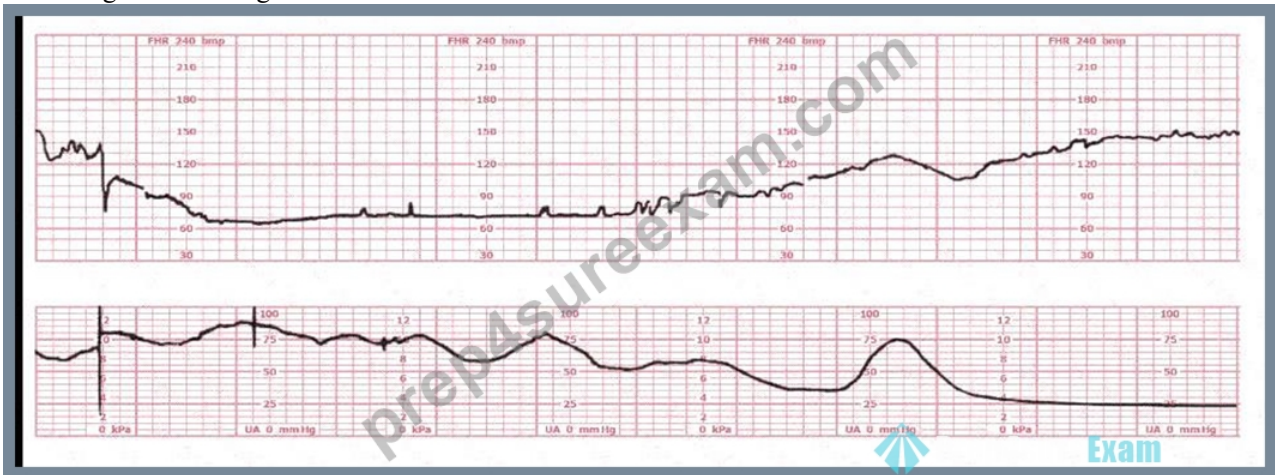
References:

AWHONN - Fetal Heart Monitoring Principles & Practices  
 Menihan - Electronic Fetal Monitoring  
 Simpson & Creehan - Perinatal Nursing  
 Creasy & Resnik - Maternal-Fetal Medicine  
 Miller's Pocket Guide

**NEW QUESTION # 41**

(Full question)

This tracing would be categorized as a



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

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (No URLs):

According to AWHONN Fetal Heart Monitoring Principles & Practice, Simpson & Miller, and the NCC C-EFM Content Outline, fetal heart rate categories are assigned based on baseline, variability, presence /absence of accelerations, and type of decelerations.

A Category II tracing includes any pattern that is not clearly normal (Category I) or clearly abnormal (Category III). Classic Category II features include:

- \* Bradycardia NOT accompanied by absent variability
- \* Tachycardia
- \* Minimal variability
- \* Marked variability
- \* Absence of accelerations after stimulation
- \* Recurrent variable decelerations with minimal or moderate variability
- \* Prolonged decelerations (#2 min but <10 min)

In this tracing, the fetus demonstrates:

- A prolonged deceleration with subsequent recovery,
- Presence of baseline variability,
- Return toward baseline but not immediately normal.

AWHONN and Simpson state that any prolonged deceleration automatically places the tracing in Category II unless variability is absent (which would escalate it to Category III). Because variability is present, it cannot be Category III.

Therefore, by NCC standards, this tracing is Category II.

### NEW QUESTION # 42

Intermittent fetal heart rate auscultation for a low-risk, spontaneous laboring patient who is 4-5 centimeters dilated should be assessed at intervals every

- A. 5-10 minutes
- B. 45-60 minutes
- C. 15-30 minutes

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (No URLs or Links) NCC aligns with AWHONN's "Practice Guidelines for Fetal Heart Monitoring", which specify the appropriate frequency of intermittent auscultation (IA) based on labor phase and risk level. For low-risk patients in active labor, IA must occur:

\* Every 15-30 minutes during active labor

\* Every 5 minutes during second stage with pushing

AWHONN and Menihan emphasize that intermittent auscultation must follow standardized time intervals to ensure adequate fetal surveillance. These intervals reflect the physiologic understanding that fetal compromise may evolve over relatively short time periods, and active labor (4-7 cm dilation) represents a time of increasing stress on fetal oxygenation.

Simpson & Creehan explain that IA frequency should increase as labor intensifies, and that the 15-30-minute interval is the nationally recognized standard for low-risk active labor. NCC's exam content domain "Fetal Assessment Methods" reinforces knowing these surveillance intervals for safe low-intervention care.

Thus, for a 4-5 cm dilated, low-risk, spontaneous labor, the correct IA interval is every 15-30 minutes.

References (No URLs)

\* NCC C-EFM Candidate Guide 2025 - Fetal Assessment Methods

\* AWHONN Practice Guidelines for Fetal Heart Monitoring, 2022-2024

\* Menihan: Electronic Fetal Monitoring

\* Simpson & Creehan: Perinatal Nursing

\* Miller: Fetal Monitoring Pocket Guide

### NEW QUESTION # 43

(Full question statement)

The American College of Obstetricians and Gynecologists (ACOG) recommends continuous electronic fetal monitoring in pregnancies when there is:

- A. A history of preterm birth
- B. Macrosomia
- C. Maternal diabetes

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Without Links:

NCC relies heavily on ACOG Practice Bulletins for risk-based monitoring decisions. ACOG identifies maternal diabetes (pregestational or poorly controlled gestational diabetes) as a key high-risk obstetric condition warranting continuous electronic fetal monitoring due to risks such as fetal hypoxia, macrosomia, and metabolic complications.

In contrast, a history of preterm birth does not necessarily require continuous monitoring unless current pregnancy complications are present.

Macrosomia alone does not automatically justify continuous EFM unless accompanied by other risk factors.

Therefore, according to NCC-aligned ACOG clinical criteria, maternal diabetes is the correct indication.

### NEW QUESTION # 44

When R-R intervals are short, the fetal heart rate is

- A. slow
- B. fast
- C. normal

**Answer: B**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources The fetal heart rate is calculated from the interval between consecutive R waves in the fetal ECG. Shorter R-R intervals indicate more beats per unit of time, therefore resulting in a higher heart rate. AWHONN and Menihan both note that fetal ECG monitoring measures instantaneous rate based on R-R spacing, and "shorter intervals correspond to fetal tachycardia." Simpson & Creehan reinforce that fetal heart rate variability and baseline are derived from these R-R intervals, with shorter intervals consistently producing faster rates. Miller's Pocket Guide describes the relationship simply: "Short R-R = faster rate; long R-R = slower rate." References:  
AWHONN - Fetal Heart Monitoring  
Menihan - Electronic Fetal Monitoring  
Simpson & Creehan - Perinatal Nursing  
Miller's Pocket Guide  
Creasy & Resnik - Maternal-Fetal Medicine

## NEW QUESTION # 45

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