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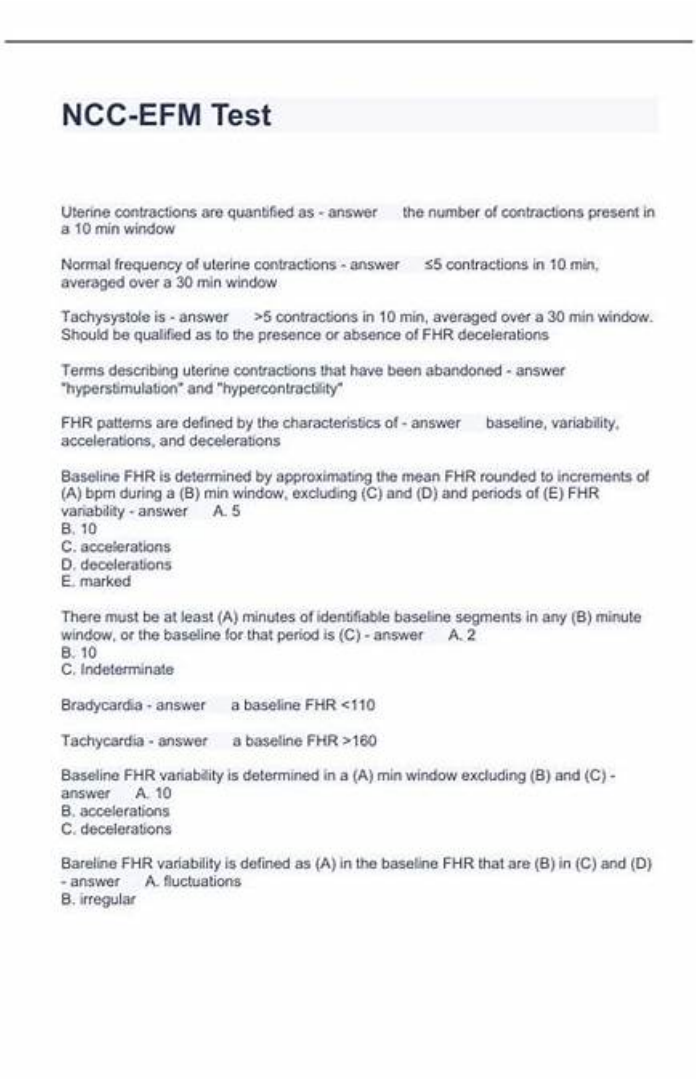

NCC-EFM Test

Uterine contractions are quantified as - answer the number of contractions present in a 10 min window

Normal frequency of uterine contractions - answer ≤5 contractions in 10 min, averaged over a 30 min window

Tachysystole is - answer >5 contractions in 10 min, averaged over a 30 min window. Should be qualified as to the presence or absence of FHR decelerations

Terms describing uterine contractions that have been abandoned - answer "hyperstimulation" and "hypercontractility"

FHR patterns are defined by the characteristics of - answer baseline, variability, accelerations, and decelerations

Baseline FHR is determined by approximating the mean FHR rounded to increments of (A) bpm during a (B) min window, excluding (C) and (D) and periods of (E) FHR variability - answer A. 5
B. 10
C. accelerations
D. decelerations
E. marked

There must be at least (A) minutes of identifiable baseline segments in any (B) minute window, or the baseline for that period is (C) - answer A. 2
B. 10
C. Indeterminate

Bradycardia - answer a baseline FHR <110

Tachycardia - answer a baseline FHR >160

Baseline FHR variability is determined in a (A) min window excluding (B) and (C) - answer A. 10
B. accelerations
C. decelerations

Bareline FHR variability is defined as (A) in the baseline FHR that are (B) in (C) and (D) - answer A. fluctuations
B. irregular

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q53-Q58):

NEW QUESTION # 53
The ratio of oxyhemoglobin to the total amount of hemoglobin available is called oxygen

- A. saturation
- B. affinity
- C. carrying capacity

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Oxygen saturation refers to the percentage of hemoglobin binding sites occupied by oxygen. NCC physiology resources, including Simpson & Creehan and Creasy & Resnik, define oxygen saturation as the
"ratio of oxyhemoglobin to total hemoglobin"-the same definition used in fetal oxygenation discussions.
Oxygen affinity refers to hemoglobin's tendency to bind oxygen (related to the oxyhemoglobin dissociation curve).
Oxygen carrying capacity refers to the total amount of oxygen hemoglobin can transport, independent of current saturation.
AWHONN and Menihan emphasize that fetal oxygenation assessment is dependent on understanding oxygen saturation, not affinity or carrying capacity, when discussing fetal hypoxemia and gas exchange.
References:
AWHONN - Fetal Heart Monitoring Principles & PracticesSimpson & Creehan - Perinatal NursingCreasy & Resnik - Maternal-Fetal MedicineMenihan - EFM ConceptsMiller's Pocket Guide

NEW QUESTION # 54
Fetal respiratory acidosis is most likely to present with which of the following fetal heart rate decelerations?

- A. Early
- B. Late
- C. Variable

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC and AWHONN physiology teachings:
* Variable decelerations caused by cord compression lead to:
* Transient interruption of umbilical venous flow
* Impaired fetal gas exchange
* Acute rise in CO#
* Respiratory acidosis (early phase of hypoxemia)
This is well documented:
* Early decelerations # head compression # NOT associated with acidemia.
* Late decelerations # uteroplacental insufficiency # metabolic acidosis, not respiratory.
Thus:
* Variable decelerations # respiratory acidosis
* Late decelerations # metabolic acidosis
Correct answer: C. Variable
References:NCC Physiology Domain; AWHONN FHMPP; Menihan EFM; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 55
The decelerations seen in the fetal monitoring tracing shown are best described as:

- A. Early
- B. Late
- C. Variable

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Accurate classification of decelerations requires evaluating their shape, onset, nadir, recovery, relationship to contractions, and variability characteristics. NCC uses the NICHD standardized definitions, reinforced across AWHONN, Miller's Pocket Guide, Menihan, Simpson, and Creasy & Resnik.
Key features in this tracing:
* Abrupt onsetThe FHR drops rapidly from baseline to nadir in less than 30 seconds-this is the defining hallmark of a variable deceleration per NICHD.
* Sharp V-shape and deep amplitudeThe tracing shows steep descents and ascents, characteristic of cord compression-type variable decelerations.
* Inconsistent timing with contractionsThe decelerations do not begin at the start of contractions (as early decelerations would) and do not consistently begin after the peak of contractions (as late decelerations would). Variable decelerations can occur before, during, or after a contraction-exactly what is demonstrated here.
* Rapid return to baselineAnother core feature of variable decelerations in NICHD/NCC definitions.
* No uniform contraction relationshipEarly decelerations are symmetrical and mirror contractions.
Late decelerations begin after the peak of the contraction. This strip does not match either pattern.
Differentiation per NCC-aligned definitions:
* Early Decelerations:Gradual onset (>30 sec), nadir mirrors contraction peak, shallow, uniform.Not present.
* Late Decelerations:Gradual descent, nadir after contraction peak, smooth shape.Not present.
* Variable Decelerations:Abrupt onset (<30 sec), variable timing, sharp V-shape, rapid recovery, often with shoulders.Exactly matches the tracing.
Therefore, according to NICHD/NCC criteria, the decelerations shown are variable decelerations.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Standardized Definitions; 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 # 56
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 # 57
When auscultating the fetal heart rate, the Doppler should be placed over the fetal:

- A. Back
- B. Chest
- C. Abdomen

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC and AWHONN standards state that the fetal heart tones are most clearly heard when the Doppler probe is placed over the fetal back, because:
* The fetal heart transmits sound most directly through the fetal spine.
* Amniotic fluid and fetal position allow the strongest conduction at the back.
* During Leopold maneuvers, identification of the back guides optimal placement.
Placing the Doppler over the abdomen or chest does not provide the strongest or most reliable fetal signal.
Therefore, the correct placement is over the fetal back.
References:NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; Simpson & Creehan Perinatal Nursing.

NEW QUESTION # 58
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