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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q12-Q17):

### NEW QUESTION # 12

A fetal heart rate pattern characteristic of fetal neurological injury and impending intrapartum fetal demise is:

- A. Marked variability
- B. **Wandering baseline**
- C. Recurrent late decelerations

**Answer: B**

#### Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

A wandering baseline is:

- \* A slow, fluctuating baseline
- \* Low amplitude
- \* No variability
- \* No accelerations

\* Indicative of severe fetal neurologic injury and terminal fetal status NCC and AWHONN describe wandering baseline as a preterminal pattern.

Why the other answers are wrong:

- \* A. Marked variability # often transient and not associated with demise.
- \* B. Recurrent lates # concerning but not a neurological-injury pattern unless variability absent.

Correct answer: C. Wandering baseline.

References:NCC Pattern Recognition; AWHONN FHMPP; Menihan; Simpson & Creehan.

#### NEW QUESTION # 13

A woman reports 12 fetal movements over one hour. The best recommendation is to:

- A. Continue to monitor for one hour
- B. **Instruct her to count again the next day**
- C. Administer a nonstress test

#### Answer: B

#### Explanation:

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

NCC and AWHONN consider fetal movement counts normal when:

- \* #10 distinct movements occur within 2 hours
- \* Or #4 movements in 1 hour for certain protocols
- \* Or #10 movements in 1 hour (common triage threshold)

This patient reports 12 movements in 1 hour, which is reassuring and requires no further testing.

Thus, recommending she continue daily kick counts at home is appropriate.

Why the other options are incorrect:

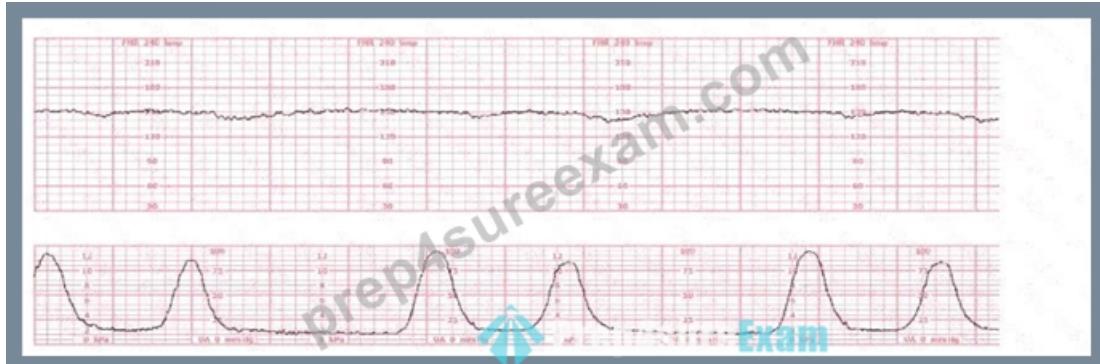
- \* A. NST is not needed because movements are normal.
- \* B. Continue to monitor is unnecessary; the test is already reassuring.

Correct choice: C. Count again the next day.

References:NCC C-EFM Candidate Guide; AWHONN Fetal Assessment guidelines; Simpson & Creehan.

#### NEW QUESTION # 14

A woman is being induced with oxytocin. The tracing shown is representative of 20 minutes. Based on this tracing, the next step would be to:



- A. **Discontinue oxytocin**
- B. Place a spiral electrode
- C. Proceed to operative birth

#### Answer: A

#### Explanation:

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

Evaluation of a tracing during oxytocin induction requires analysis of fetal status (baseline, variability, accelerations, decelerations) and uterine activity, with attention to tachysystole and fetal intolerance. NCC, AWHONN, Miller, Menihan, Simpson, and the NICHD guidelines all emphasize that oxytocin must be adjusted based on fetal response and contraction frequency.

#### Baseline:

The fetal heart rate baseline is approximately 150 bpm, which is within the normal range of 110-160 bpm.

#### Variability:

The tracing shows minimal variability (approximately 1-4 bpm amplitude). Minimal variability for a sustained period is categorized as a Category II pattern under NCC/NICHD classification.

#### Accelerations:

No accelerations are present during the 20-minute representative segment.

#### Decelerations:

There are no recurrent variable, no recurrent late, and no prolonged decelerations.

#### Uterine Activity:

The tracing shows very frequent contractions—approximately every 1½ to 2 minutes, which meets the NCC definition of tachysystole when averaged over 10 minutes (more than 5 contractions in 10 minutes).

According to NCC and AWHONN standards, when tachysystole is present with minimal variability, oxytocin must be reduced or discontinued even in the absence of late decelerations.

#### Clinical decision-making (per NCC principles):

NCC emphasizes that management of Category II patterns during induction starts with intrauterine resuscitative measures, including decreasing or stopping oxytocin when uterine activity is excessive or fetal response is suboptimal. Minimal variability with tachysystole requires correction of uterine stimulation before escalating to invasive monitoring or considering operative birth.

Option B (place a spiral electrode) is not indicated because the pattern is clearly visible and the priority is correcting uterine overstimulation, not refining the tracing.

Option C (operative birth) is not indicated; there is no Category III pattern or recurrent decelerations.

Option A (discontinue oxytocin) is the correct first-line action according to NCC-aligned guidelines when tachysystole and minimal variability occur.

#### References:

NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Three-Tier FHR Interpretation System; 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 # 15

This fetal heart rate tracing represents:



- A. Prolonged acceleration
- B. Coupling of contractions
- C. Category I tracing

#### Answer: B

#### Explanation:

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

The lower uterine tracing shows a repetitive contraction pattern characterized by pairs of contractions occurring close together, followed by a longer interval. This is known as "uterine contraction coupling." Key features confirming coupling:

- \* Two contractions occur back-to-back, separated by only a few seconds.
- \* Then a longer rest period occurs before the next pair.
- \* This pattern persists over several minutes.
- \* FHR remains normal with moderate variability and no decelerations.

Coupling is a uterine activity pattern, not a fetal heart rate abnormality.

Why the other answers are incorrect

A). Category I tracing

- \* While the FHR itself may appear reassuring, the question is explicitly about the pattern shown, which is (per NCC classification) a uterine pattern, not a category designation.

C). Prolonged acceleration

- \* A prolonged acceleration would be a fetal heart rate increase  $\geq 15$  bpm lasting  $\geq 2$  minutes but  $< 10$  minutes.
- \* No such FHR increase appears on the strip.

Thus, the correct interpretation is B. Coupling of contractions.

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

## NEW QUESTION # 16

(Full question)

Spontaneous fetal heart rate accelerations indicate

- A. integrated response of the fetal central nervous system
- B. dominance of the fetal sympathetic nervous system
- C. immaturity of the fetal parasympathetic nervous system

**Answer: A**

Explanation:

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

NCC references (AWHONN, Menihan, Simpson, Creasy & Resnik) consistently state that fetal accelerations are a reassuring sign of intact neurologic function. Accelerations represent the interaction of both the sympathetic and parasympathetic branches moderated through the central nervous system, reflecting effective autonomic regulation.

AWHONN specifically describes fetal accelerations as:

- \* A maturity marker of CNS function,
- \* Reflecting vigorous fetal movement,
- \* Demonstrating adequate oxygenation,
- \* Indicating a well-oxygenated brainstem and cortex.

Simpson & Miller emphasize that accelerations require both systems to be functioning and respond appropriately, which confirms CNS integration, not sympathetic or parasympathetic dominance alone.

Therefore, spontaneous accelerations indicate an integrated CNS response, making Option C the correct NCC-aligned answer.

## NEW QUESTION # 17

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