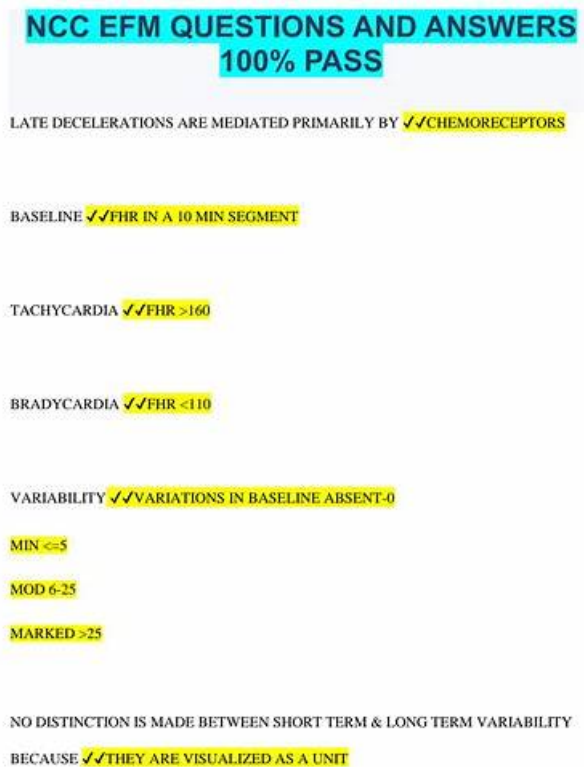


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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q63-Q68):

### NEW QUESTION # 63

The tracing shown is a:

□

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

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References (No URLs):

Interpretation of fetal heart rate (FHR) tracings in the NCC C-EFM exam follows the standardized NICHD three-tier classification, which is fully adopted in NCC's content outline and recommended references such as AWHONN Fetal Heart Monitoring Principles & Practices, Miller's EFM Pocket Guide, Menihan, Simpson's Perinatal Nursing, and Creasy & Resnik.

Baseline:

The tracing demonstrates an FHR baseline around 145-150 bpm, which falls within the normal range of 110-160 bpm. NCC references define baseline as the mean FHR rounded to increments of 5 bpm over a 10-minute window.

Variability:

The strip shows minimal variability, with amplitude fluctuations approximately 0-2 bpm.

According to NCC-aligned definitions:

\* Moderate variability: 6-25 bpm

\* Minimal variability: 1-5 bpm

\* Absent variability: undetectable amplitude

This tracing shows minimal variability, not moderate, so it cannot be Category I.

Accelerations:

No accelerations are present. Lack of accelerations alone does not classify the tracing as Category III.

Decelerations:

There are no recurrent late decelerations, no recurrent variable decelerations, and no prolonged decelerations. Without these, and with minimal variability, the tracing does not meet Category III criteria.

Category III criteria (per NICHD/NCC):

Must include at least one of the following:

\* Absent variability with recurrent late decelerations

\* Absent variability with recurrent variable decelerations

\* Absent variability with bradycardia

\* Sinusoidal pattern

None of these are present.

Category II criteria (per NICHD/NCC):

Category II includes tracings that are not Category I or III.

Examples specifically listed include:

\* Minimal variability

\* Absent accelerations after fetal stimulation

\* Tachycardia

\* Bradycardia without absent variability

\* Variable or late decelerations occurring intermittently

Because this tracing shows minimal variability, a normal baseline, no accelerations, and no recurrent decelerations, it fits squarely into Category II.

Therefore, the correct classification is Category II.

References: NCC C-EFM Candidate Guide and Content Outline (2025); 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; NICHD Three-Tier FHR Interpretation System.

### NEW QUESTION # 64

A woman at 39-weeks gestation is in early labor, 2-3 cm dilated, 85% effaced, and -2 station. Based on the fetal heart rate tracing shown, what is the most appropriate first intervention?

□

- A. Administer an IV fluid bolus
- B. Adjust the fetal monitor

- C. Administer terbutaline

**Answer: B**

Explanation:

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

The tracing shows significant artifact, periods of signal loss, and abrupt changes inconsistent with physiologic fetal patterns. This is typical of poor signal quality, not actual fetal decelerations. In early labor at -2 station, external FHR monitoring often loses contact due to fetal position and maternal movement.

NCC and AWHONN emphasize the following when artifact is present:

- \* Correct signal quality before interpreting the tracing.
- \* Troubleshooting steps include:- Adjusting transducer location- Ensuring adequate ultrasound gel- Repositioning the mother- Checking for maternal heart rate contamination Why the other options are incorrect:
- \* B. IV fluid bolus - Indicated for hypotension or late decelerations, not for artifact.
- \* C. Terbutaline - Used for tachysystole with fetal intolerance; there is no tachysystole shown.

Thus, the correct first step is A. Adjust the fetal monitor.

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

### NEW QUESTION # 65

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

- A. Contraction pattern
- B. Patient pain level
- **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 # 66

This tracing demonstrates:

□

- **A. Prolonged deceleration**
- B. Bradycardia
- C. Category III tracing

**Answer: A**

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

A prolonged deceleration is defined by NICHD and NCC as:

- \* A deceleration lasting #2 minutes but <10 minutes
- \* Decrease in FHR of #15 bpm
- \* Can occur with or without uterine contractions

This tracing shows:

- \* A deep drop in FHR down to ~60-70 bpm
- \* Duration lasting several minutes
- \* Recovery back to baseline

\* Moderate variability present afterward

Because variability remains present and the tracing does not show:

\* Absent variability

\* Recurrent late decelerations

\* Recurrent variable decelerations with absent variability

\* Bradycardia for #10 minutes

...it does not meet criteria for Category III.

It is also not bradycardia, because bradycardia requires:

\* Baseline <110 bpm for 10 minutes or longer

Therefore the correct interpretation is a prolonged deceleration.

References: NCC C-EFM Candidate Guide; NICHD FHR Definitions; AWHONN FHMPP; Menihan; Simpson & Creehan.

### NEW QUESTION # 67

A key differentiating factor when determining if a deceleration is early or late is the

- A. timing in relation to contractions
- B. depth of the deceleration
- C. onset to nadir

**Answer: A**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) AWHONN and Menihan clearly state that classification of decelerations is determined by their timing relative to uterine contractions:

\* Early decelerations: "mirror the contraction; onset, nadir, and recovery occur simultaneously with the contraction."

\* Late decelerations: "begin after the contraction begins and return to baseline after the contraction ends." Depth is not a differentiating feature, as both early and late decelerations may vary in depth. The onset-to- nadir interval is used to differentiate variable vs. early/late, not early vs. late.

Thus, timing relative to contractions is the correct NCC-supported answer.

### NEW QUESTION # 68

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