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SOPHIA BENNETT 2024/2025 Wednesday, August 21, 2024 12:13 PM

## NCC EFM practice Exam Questions and Answers (100% Pass)

Which of the following factors can have a negative effect on uterine blood flow?

- a. Hypertension
- b. Epidural
- c. Hemorrhage
- d. Diabetes
- e. All of the above - Answer✓✓-e. All of the above

Stimulating the vagus nerve typically produces:

- a. A decrease in the heart rate
- b. An increase in the heart rate
- c. An increase in stroke volume
- d. No change - Answer✓✓-a. A decrease in the heart rate

The vagus nerve begins maturation 26 to 28 weeks. Its dominance results in what effect to the FHR baseline?

- a. Increases baseline
- b. Decreases baseline - Answer✓✓-b. Decreases baseline

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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q28-Q33):

### NEW QUESTION # 28

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

### Answer: B

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 # 29

A fetal heart rate deceleration that is episodic is a/an:

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

### Answer: B

Explanation:

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

NCC and NICHD differentiate:

- \* Periodic decelerations - those occurring with contractions
- \* Episodic decelerations - those occurring independent of contractions

Deceleration types:

- \* Early - periodic (mirror contractions)
- \* Late - periodic (after peak of contraction)

\* Variable - may be periodic or episodic, and are the only type strongly associated with episodic patterns\*\* Therefore, the only deceleration type that is characteristically episodic is a variable deceleration.

Correct answer: C. Variable deceleration

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

### NEW QUESTION # 30

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

**Answer: C**

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 # 31

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 # 32

A woman in labor has been pushing for 4 hours. For the last 2 hours, there have been recurrent variable decelerations. Variability has evolved from moderate to minimal. Cervical exam is 10/100%

/+2, fetal head OP. There has been no fetal descent for the last 45 minutes. Based on the tracing shown, the most reasonable approach is

- A. vacuum-assisted vaginal birth
- B. cesarean birth
- C. continued pushing

### Answer: B

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) According to the NCC C-EFM Exam Outline and AWHONN Fetal Heart Monitoring (5th & 6th ed.), recurrent variable decelerations with progressive reduction in variability reflect worsening fetal hypoxia, especially when coupled with prolonged second stage and arrest of descent.

AWHONN and Menihan both state that:

\* "Minimal variability with recurrent decelerations indicates inability of the fetus to maintain adequate oxygenation."

\* "Failure of descent in second stage with non-reassuring patterns requires operative delivery." Creasy & Resnik emphasize that operative vaginal birth requires:

- (1) fetal head at +2 station or below,
- (2) favorable position,
- (3) reassuring fetal status.

Here, the fetus is OP, descent has arrested, and FHR is non-reassuring. This contraindicates vacuum extraction.

Therefore, the appropriate management under NCC competencies is cesarean birth.

## NEW QUESTION # 33

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