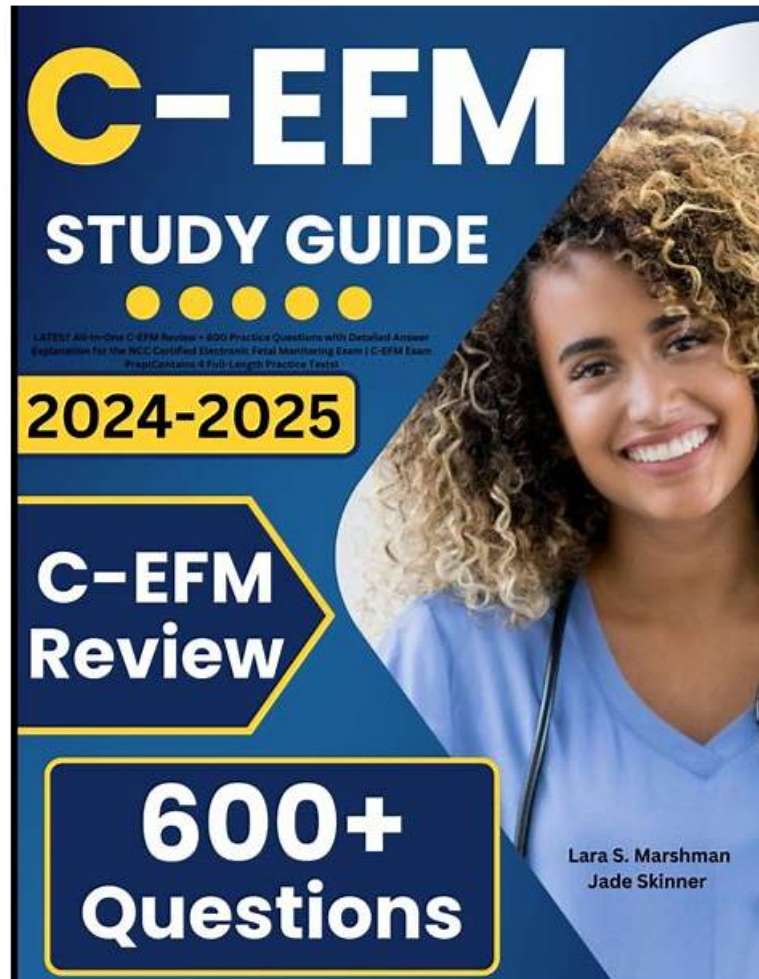


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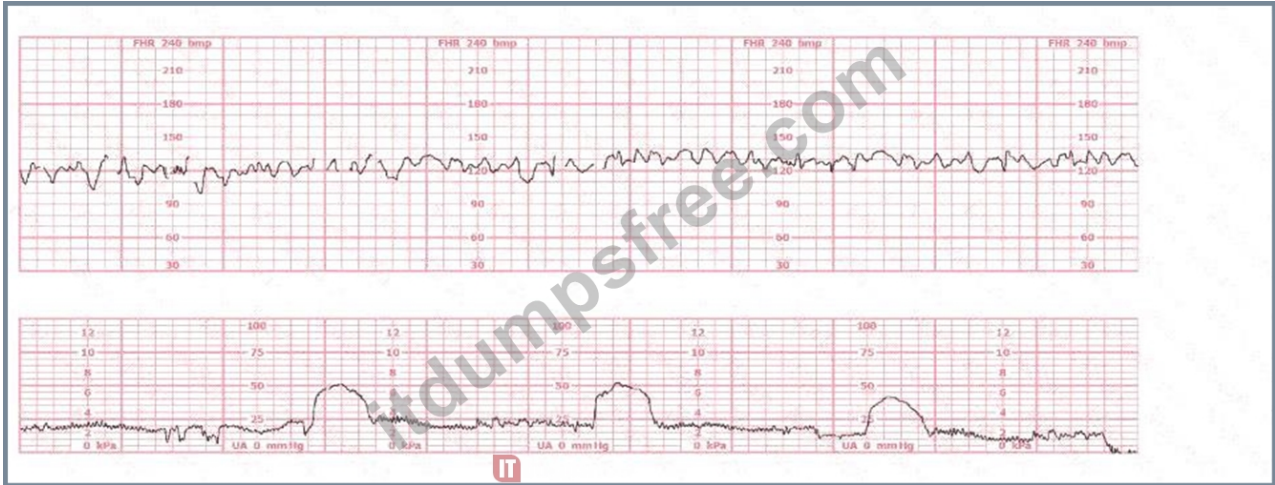
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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q35-Q40):

NEW QUESTION # 35

A woman at 34-weeks gestation is in active labor after spontaneous rupture of membranes. Accelerations should be documented as



- A. present 15×15
- B. absent
- C. present 10×10

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (No URLs)

For fetuses before 32-34 weeks, the National Certification Corporation (NCC) follows the physiologic standards established by AWHONN, Simpson & Creehan, Menihan, and Creasy & Resnik, which emphasize that preterm fetuses have less mature autonomic nervous system development, resulting in smaller and shorter accelerations.

According to the NCC C-EFM Exam Content Outline (Pattern Recognition & Intervention) and the AWHONN Fetal Heart Monitoring Principles (2022-2024):

* Preterm fetuses (<32 weeks) normally demonstrate 10 bpm × 10 sec accelerations.

* By approximately 32-34 weeks, accelerations may begin transitioning toward 15×15, but the accepted standard for documentation at 34 weeks remains 10×10, unless clearly meeting 15×15 criteria.

* NCC emphasizes using gestational-age-appropriate criteria for documenting accelerations, because autonomic reactivity increases gradually and is not fully comparable to term until after 32-34 weeks.

Menihan's Electronic Fetal Monitoring also states that preterm fetuses "should be evaluated with the 10×10 rule until it is clear that the fetus is demonstrating mature 15×15 acceleratory capacity." Simpson & Creehan reinforce this point, noting that accelerations in late preterm gestations "may not consistently reach 15 bpm for 15 seconds, and thus 10×10 remains the appropriate designation." Since the patient is 34 weeks, the fetus is late-preterm and may not reliably meet the full 15×15 criteria; therefore, the correct documentation standard remains 10×10.

Thus, accelerations should be charted as:

"Present 10×10."

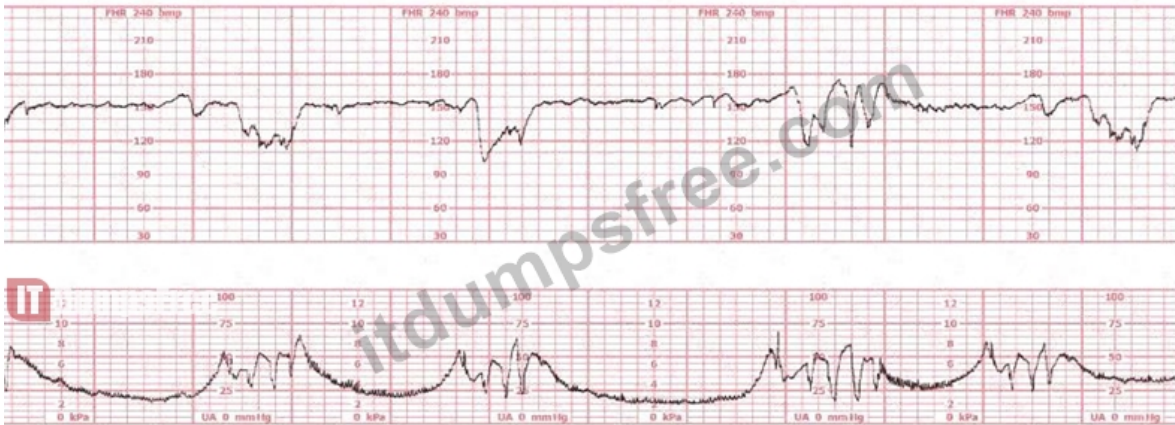
References

- * NCC C-EFM Candidate Guide 2025 - Content Domain: Pattern Recognition and Intervention
- * AWHONN Fetal Heart Monitoring Principles & Practices, 2022-2024
- * Menihan: Electronic Fetal Monitoring: Concepts and Applications
- * Simpson & Creehan: Perinatal Nursing
- * Miller: Fetal Monitoring Pocket Guide
- * Creasy & Resnik: Maternal-Fetal Medicine

NEW QUESTION # 36

A woman at 39-weeks gestation is being induced. She has chronic hypertension controlled by methyldopa (Aldomet). Spontaneous

rupture of membranes has occurred; she is 10 cm dilated and at +1 station. The fetal monitor tracing shown is obtained by spiral electrode and tocodynamometer. The next best appropriate action is to:



- A. Administer terbutaline
- **B. Modify pushing**
- C. Consider amnioinfusion

Answer: B

Explanation:

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

The tracing shows recurrent variable decelerations deepening during contractions as the patient is fully dilated and at +1 station. NCC's Pattern Recognition and Intervention framework states:

* During second stage (complete dilation), variable decelerations commonly occur from cord compression caused by head descent and maternal pushing efforts.

* The FIRST correction for pushing-associated recurrent variable decelerations is modifying the pushing technique:

- * Side-lying pushing
- * Pushing with every other contraction
- * Open-glottis pushing
- * Allowing passive descent

These measures relieve head compression and reduce the severity of variable decelerations.

Why the other answers are incorrect

A). Administer terbutaline

- * Terbutaline is given for tachysystole with fetal intolerance.
- * This tracing does not show tachysystole.
- * The pattern is timing-related to pushing, not uterine overstimulation.

B). Consider amnioinfusion

* Amnioinfusion is used for recurrent variable decelerations before complete dilation, when membrane rupture + low fluid is suspected.

* At 10 cm and +1, the fetal head is deep in the pelvis, and the cause of variables is head compression, not cord compression due to oligohydramnios.

* Also, amnioinfusion is impractical and not beneficial at this stage.

Therefore, the correct answer is C. Modify pushing.

References: NCC C-EFM Candidate Guide; NCC Content Outline; AWHONN Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 37

When a difference in interpretation occurs over a non-emergent electronic fetal heart rate tracing, the first step toward resolution is to:

- A. Follow the chain of command
- **B. Have the involved clinicians review the tracing together**
- C. Document the incident in the medical record

Answer: B

Explanation:

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

NCC's Professional Issues domain emphasizes communication, collaboration, and team-based interpretation of electronic fetal monitoring tracings.

For non-emergent differences in interpretation, the first step is:

* Discussion and joint review of the tracing by the involved clinicians.

Only if disagreement persists should the chain of command be used. Documentation occurs after consensus or escalation-not as the first step.

Thus, the appropriate first step is C. Have the involved clinicians review the tracing together.

References: NCC C-EFM Candidate Guide; AWHONN Standards for Professional Fetal Monitoring Practice; TeamSTEPPS principles.

NEW QUESTION # 38

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

Answer: A

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 # 39

An internal electronic fetal monitor continues to record artifact despite equipment troubleshooting and replacement of the spiral electrode. The next action is to:

- A. Auscultate the fetal heart rate
- B. Reposition the woman
- C. Provide oxygen

Answer: A

Explanation:

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

When internal monitoring continues to record artifact despite:

- * Changing the scalp electrode
- * Ensuring correct attachment
- * Checking cable connections
- * Confirming maternal movement is not the cause

NCC requires confirmation of fetal well-being using another modality.

The correct next step is direct auscultation with Doppler or fetoscope.

Why other answers are incorrect:

- * Oxygen is not indicated for equipment malfunction.
- * Repositioning does not resolve internal FHR artifact.

Thus, Auscultate the fetal heart rate is the appropriate next step.

References: NCC C-EFM Candidate Guide; AWHONN; Miller's Pocket Guide; Menihan.

NEW QUESTION # 40

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