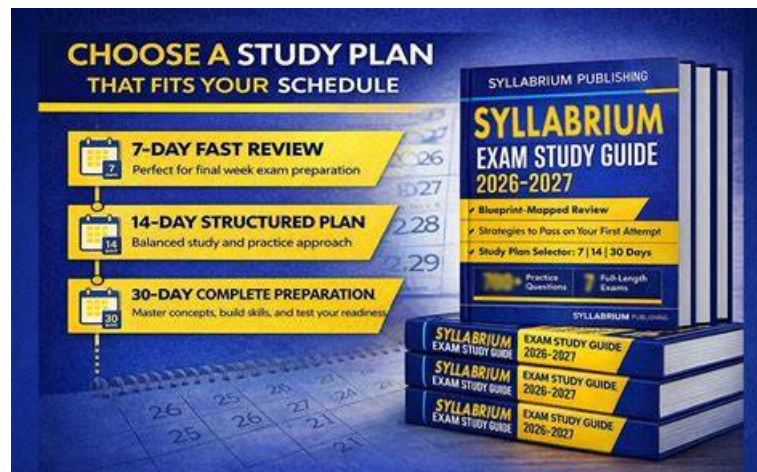


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NCC EFM Exam Syllabus Topics:

Section	Weight	Objectives
Topic 1: Pattern Recognition and Intervention	70%	- Clinical decision-making and interventions - Interpretation per NICHD standards - Fetal heart rate patterns classification - Tracing evaluation and management
Topic 2: Professional Issues	5%	- Safety and quality improvement - Documentation standards - Legal and ethical aspects
Topic 3: Physiology	11%	- Uteroplacental function - Factors affecting fetal oxygenation - Fetal cardiovascular physiology
Topic 4: Electronic Monitoring Equipment	5%	- Troubleshooting artifacts - Proper application and use - Calibration and accuracy
Topic 5: Fetal Assessment and Methods	9%	- Indications for monitoring - Correlation with clinical status - Auxiliary assessment techniques

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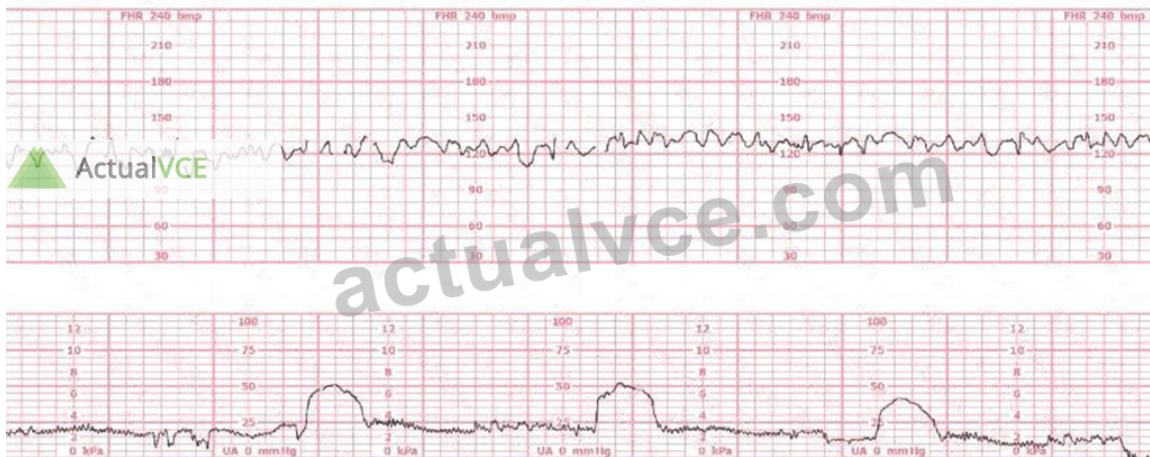
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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q62-Q67):

NEW QUESTION # 62

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



- A. absent
- B. present 15×15
- 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 # 63

When R-R intervals are short, the fetal heart rate is

- A. normal
- B. slow
- C. fast

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources The fetal heart rate is calculated from the interval between consecutive R waves in the fetal ECG. Shorter R-R intervals indicate more beats per unit of time, therefore resulting in a higher heart rate. AWHONN and Menihan both note that fetal ECG monitoring measures instantaneous rate based on R-R spacing, and "shorter intervals correspond to fetal tachycardia." Simpson & Creehan reinforce that fetal heart rate variability and baseline are derived from these R-R intervals, with shorter intervals consistently producing faster rates. Miller's Pocket Guide describes the relationship simply: "Short R-R = faster rate; long R-R = slower rate." References:

AWHONN - Fetal Heart Monitoring
Menihan - Electronic Fetal Monitoring
Simpson & Creehan - Perinatal Nursing
Miller's Pocket Guide
Creasy & Resnik - Maternal-Fetal Medicine

NEW QUESTION # 64

The fetal heart rate baseline is

- A. established between periodic and episodic changes
- B. documented in a 15 beats per minute range
- C. normally between 110 and 170 beats per minute

Answer: A

Explanation:

Comprehensive and Detailed Explanation (From NCC C-EFM-Referenced Sources) The NCC C-EFM exam outline, along with AWHONN and Miller's Pocket Guide, define baseline fetal heart rate as the mean FHR rounded to increments of 5 bpm, measured over a 10-minute window, excluding:

- * accelerations
- * decelerations
- * periods of marked variability
- * any segments differing by >25 bpm

This aligns with ACOG, AWHONN, and Simpson's interpretation standards.

Option A is incorrect: the baseline is not documented as a 15-bpm range; it is documented as a single value (e.g., 140 bpm).

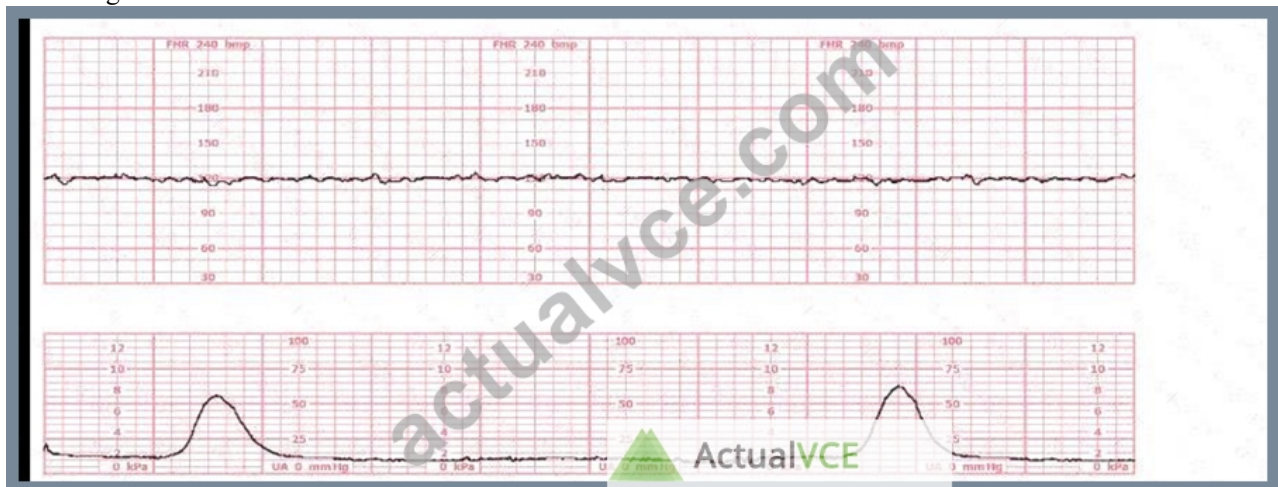
Option C is incorrect: the correct NCC/ACOG standardized normal baseline is 110-160 bpm, not 170.

Exact Extract Concepts Referenced:

- "Baseline is determined over a 10-minute period excluding periodic or episodic changes." (AWHONN FHR Principles)
- "Baseline is the mean FHR rounded to 5-bpm increments." (Miller's Pocket Guide)
- "Normal baseline is 110-160 bpm" (Simpson & Menihan; Creasy & Resnik)

NEW QUESTION # 65

This tracing reflects:



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

Answer: C

Explanation:

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

In NCC C-EFM interpretation, classification of a fetal heart tracing is based on NICHD's three-tier system:

Category I, II, and III. Category III represents an abnormal tracing requiring immediate evaluation and prompt intervention.

Key findings in this tracing:

- * Baseline: Baseline is approximately 140 bpm, within the normal range (110-160 bpm). Baseline alone does not determine category.

- * Variability: The tracing shows absent variability:

- * No beat-to-beat oscillations

- * Flat, minimal fluctuation NICHD and NCC define absent variability as amplitude range undetectable.

- * Accelerations: No accelerations are present.

- * Decelerations: The strip does not show decelerations or bradycardia. However, absent variability alone with no accelerations for 20 minutes is highly concerning.

Category Classification per NICHD/NCC:

Category III criteria include ANY of the following:

- * Absent variability with recurrent late decelerations

- * Absent variability with recurrent variable decelerations

- * Absent variability with bradycardia

- * Sinusoidal pattern

Also recognized as Category III:

- * Persistent absent variability lasting ≥20 minutes with no accelerations, which is strongly suggestive of fetal acidemia when sustained.

This tracing shows:

- * Absent variability (flat line)

- * No accelerations

- * Persisting over an extended period

Under NCC and AWHONN guidance:

A persistently flat tracing must be classified as Category III unless proven otherwise (e.g., fetal sleep, maternal medications), and it requires immediate intrauterine resuscitation and evaluation for potential expedited delivery.

Why Category I is NOT correct:

Category I requires:

- * Moderate variability

- * No late or variable decelerations This tracing does not have moderate variability.

Why Category II is NOT correct:

Category II includes minimal variability, marked variability, intermittent variables/late, absence of accelerations after stimulation.

This tracing is worse than Category II because variability is absent, not minimal.

Thus, the tracing fits Category III.

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 # 66

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

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

Answer: B

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 CO₂

- * 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 # 67

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