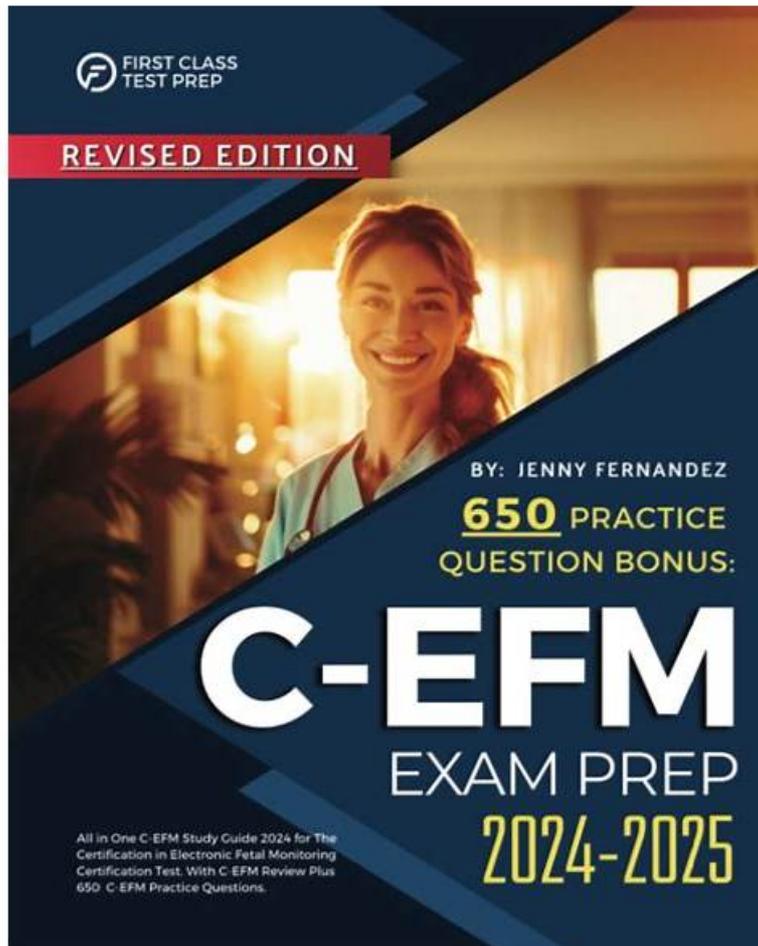


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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q85-Q90):

NEW QUESTION # 85

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

Answer: A

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 # 86

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

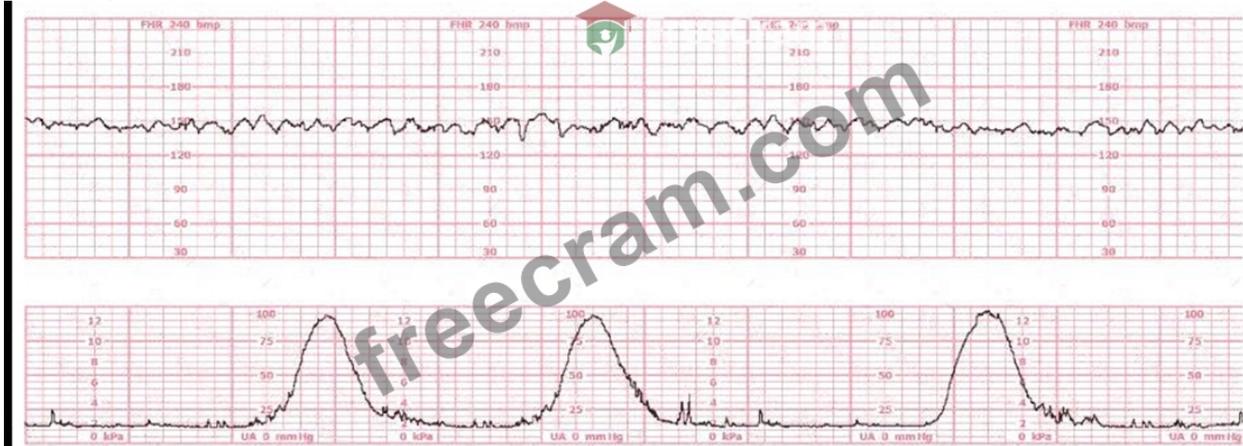
operative vaginal birth requires:

- (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 # 87

This tracing reflects



- A. Moderate variability
- B. Sinusoidal pattern
- C. Minimal variability

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC-Recommended Sources Only) The fetal heart rate (FHR) tracing shown demonstrates a baseline approximately 135-145 bpm with fluctuations of 6-25 bpm, a hallmark of moderate variability. Moderate variability is defined in all NCC- endorsed resources as the normal amplitude range of 6-25 bpm around the fetal baseline.

According to the AWHONN Fetal Heart Monitoring Principles & Practices (2022-2024), moderate variability is considered the single most reliable indicator of adequate fetal oxygenation and intact neurologic pathways, specifically reflecting well-functioning sympathetic and parasympathetic interplay.

The NICHD/NCC standardized definitions included in the NCC C-EFM Candidate Guide state:

* Minimal variability: amplitude range \leq 5 bpm

* Moderate variability: amplitude range 6-25 bpm

* Marked variability: amplitude $>$ 25 bpm

* Sinusoidal pattern: smooth, undulating waveform, 3-5 cycles per minute, equal amplitude, absent beat-to-beat variability The tracing provided does not show the repetitive, smooth, wave-like pattern of a sinusoidal rhythm, nor does it show flattening associated with minimal variability. Instead, it includes continuous beat-to-beat fluctuation within the moderate range, without periods of absent or minimal variability.

Menihan's Electronic Fetal Monitoring (5th ed.) and Simpson & Creehan's Perinatal Nursing (5th ed.) both emphasize that moderate variability is:

* A reassuring feature

* Indicative of adequate fetal CNS oxygenation

* Expected in a reactive, well-oxygenated fetus

* A key criterion for Category I classification

Additionally, Miller's EFM Pocket Guide reiterates that variability between 6-25 bpm is considered the normal (moderate) fetal autonomic response and is not a sinusoidal pattern, which has a fixed amplitude and frequency.

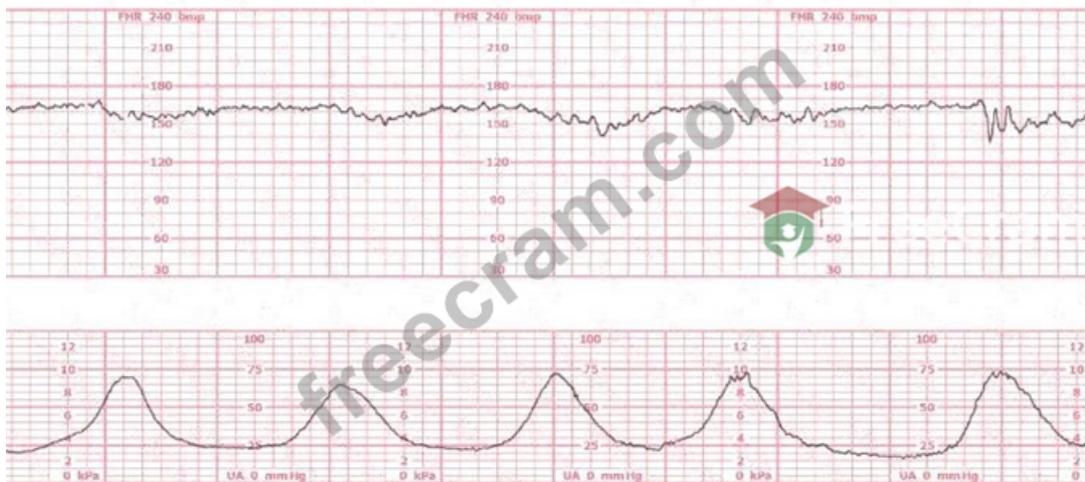
Therefore, based on NCC-standard definitions and the observed amplitude, the correct interpretation is moderate variability.

References (No URLs):

AWHONN Fetal Heart Monitoring Principles & Practices; NCC C-EFM Candidate Guide 2025; Simpson & Creehan Perinatal Nursing; Menihan Electronic Fetal Monitoring; Miller's Pocket Guide to Fetal Monitoring; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 88

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 # 89

A patient presents at 38-weeks gestation with complaints of decreased fetal movement and ruptured membranes. The fetal heart rate is not able to be determined with an external ultrasound monitor. A spiral electrode is placed, and the tracing shows a rate of 90

bpm. What is the next most appropriate action?

- A. Request for an urgent bedside ultrasound
- B. Intrauterine resuscitation measures
- C. Palpation of the maternal radial pulse

Answer: C

Explanation:

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

Whenever a fetal heart rate is unexpectedly low (such as 90 bpm), the FIRST step per NCC and AWHONN is to confirm that the signal is fetal, not maternal.

Even internal spiral electrodes can capture maternal heart rate, especially after:

- * Rupture of membranes
- * Maternal hypotension
- * Maternal dehydration
- * Maternal tachycardia or bradycardia

Thus, the first, most immediate action is:

Palpate the maternal radial pulse to determine whether the tracing is maternal or fetal.

If rates match # the monitor is falsely detecting the maternal pulse.

If rates differ # confirm true fetal bradycardia and begin intrauterine resuscitation.

Why the other options are incorrect:

- * A. Intrauterine resuscitation - should NOT begin before confirming the tracing is fetal.
- * C. Bedside ultrasound - appropriate after confirming that the tracing is not maternal, not before.

Correct answer: B. Palpation of the maternal radial pulse.

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

NEW QUESTION # 90

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