

100% Pass 2026 NCC EFM: Certified - Electronic Fetal Monitoring–Reliable Detailed Study Plan

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**NCC EFM fetal monitoring
practice Questions And Answers 100% Pass**

1. A woman in the first stage of labor is to have a direct fetal scalp electrode placed. The fetal presenting part is not engaged but membranes have been ruptured. Placement of the fetal scalp electrode increases the risk of

- a. cord prolapse
- b. prolonged labor
- c. neonatal hematoma - answer✓a

2. When variable decelerations persist despite intrauterine resuscitation, a factor that would lead to consideration of letting labor continue to delivery is

- a. acceleration after vibroacoustics
- b. regular fetal breathing motions
- c. no tachysystole - answer✓a

A characteristic of a sinusoidal heart rate pattern is

- a. amplitude of 5 to 15 beats/min above and below the baseline
- b. a fixed baseline variability range for 10 or more minutes
- c. bradycardia with regular oscillation pattern - answer✓a

Since the introduction of electronic fetal monitoring, what effects have occurred?

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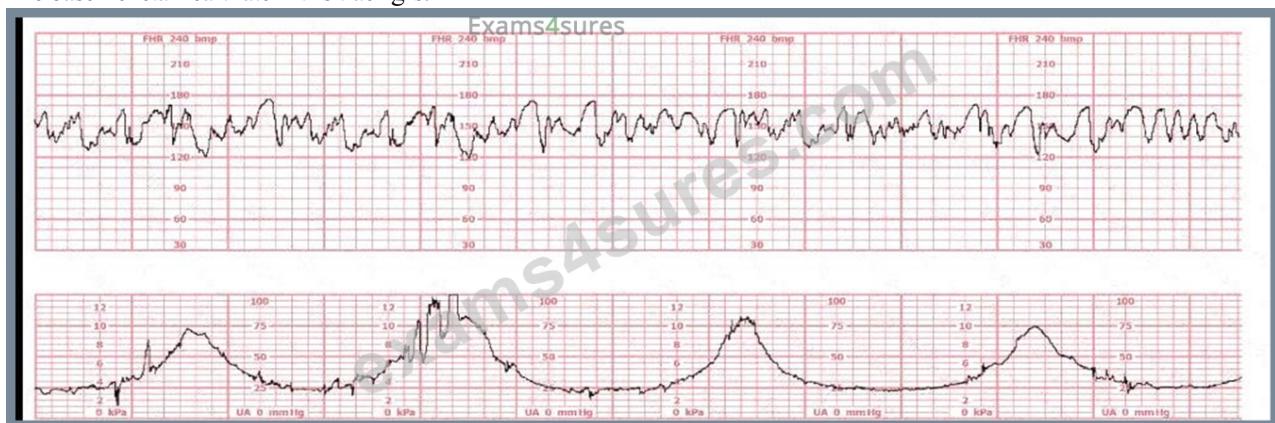
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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q103-Q108):

NEW QUESTION # 103

The baseline fetal heart rate in this tracing is:



- A. 155 beats per minute
- B. Tachycardia
- C. Indeterminate

Answer: B

Explanation:

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

On the tracing:

- * FHR consistently ranges 170-185 bpm
- * Variability remains present, confirming adequate signal.
- * This pattern persists for the required minimum 10-minute baseline window.

NICHHD/NCC define fetal tachycardia as:

- * Baseline > 160 bpm for at least 10 minutes

Because the FHR is well above 160 for the whole reviewable period, the baseline is tachycardic.

Why the other answers are incorrect:

- * A. 155 bpm - Too low; FHR visually averages well above this.
- * B. Indeterminate - Not applicable; variability is clear and the tracing meets the #10-minute rule.

Correct answer: C. Tachycardia

References: NICHHD Definitions; NCC C-EFM Candidate Guide; AWHONN; Miller; Menihan.

NEW QUESTION # 104

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. 5-10 minutes
- C. 15-30 minutes

Answer: C

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 # 105

When monitoring monochorionic-monoamniotic twins, which of the following fetal heart rate patterns would be anticipated?

- A. Variable decelerations
- B. Minimal variability
- C. Baseline tachycardia

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) Mono-mono twins share a single amniotic cavity, which significantly increases the risk of cord entanglement, a concept highlighted in AWHONN FHM, Creasy & Resnik Maternal-Fetal Medicine, and Miller's EFM Pocket Guide. These texts emphasize:

- * "Cord entanglement is nearly universal in monoamniotic twins."
- * "Variable decelerations are common due to recurrent cord compression." Baseline tachycardia or minimal variability are not expected baseline characteristics, but may appear only in pathologic circumstances.

Thus, variable decelerations are the expected and anticipated FHR pattern in mono-mono twins.

NEW QUESTION # 106

A pattern of recurrent variable decelerations would move from Category II to Category III if what fetal heart rate change occurs?

- A. Tachysystole
- B. Late decelerations
- C. Absent variability

Answer: C

NEW QUESTION # 107

Interventions undertaken to address fetal tachycardia are targeted at maximizing

- A. uteroplacental perfusion
- B. sympathetic autonomic tone
- C. maternal circulation

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Fetal tachycardia is typically caused by maternal fever, dehydration, hypoxia, medications, infection, or fetal stress. AWHONN and Simpson & Creehan emphasize that management focuses on improving oxygen delivery across the placenta, which is governed by uteroplacental perfusion.

Menihan's EFM text states that "interventions for fetal tachycardia must address oxygen transfer by optimizing uteroplacental blood flow," including hydration, reducing uterine activity, maternal repositioning, and treating maternal fever.

Increasing maternal circulation alone is insufficient unless it improves placental blood flow. Enhancing fetal sympathetic tone is not a clinical goal and would worsen tachycardia.

Creasy & Resnik highlight that fetal heart rate abnormalities resolve when uteroplacental perfusion is restored, confirming this as the primary target of intervention.

References:

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

NEW QUESTION # 108

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