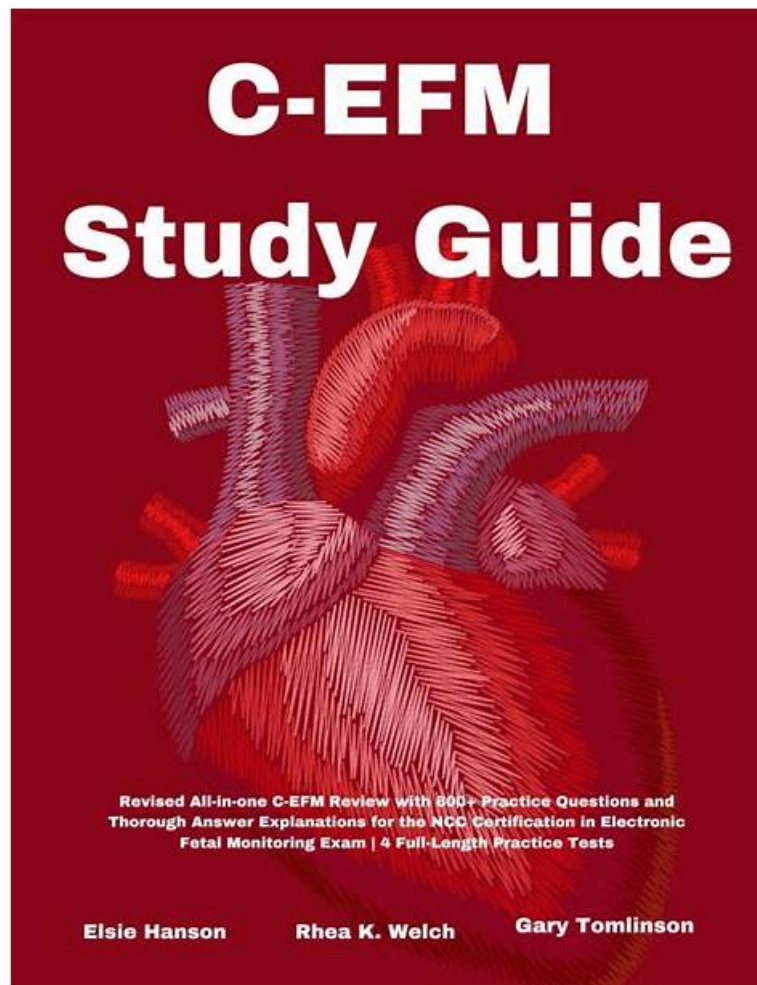


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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q36-Q41):

NEW QUESTION # 36

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

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

Answer: B

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Category III criteria include:

- * Absent variability with recurrent variable decelerations
- * Absent variability with recurrent lates
- * Absent variability with bradycardia
- * Sinusoidal pattern

Thus, recurrent variables become Category III when accompanied by absent variability, indicating fetal decompensation.

Why the other answers are wrong:

- * B. Late decelerations # Category III only if combined with absent variability.
- * C. Tachysystole # Contraction pattern, not a FHR characteristic.

Correct answer: Absent variability.

References: NCC C-EFM Candidate Guide; NICHD Definitions; AWHONN FHMPP.

NEW QUESTION # 37

The baseline heart rate of a 28-week fetus is 170 bpm. The next step is to:

- A. Continue observation
- **B. Assess maternal vital signs**
- C. Perform a biophysical profile

Answer: B

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Without Any URLs or Links:

NCC references (AWHONN, Simpson, Menihan) and the Physiology domain emphasize that baseline fetal heart rate is higher at earlier gestational ages due to predominant sympathetic tone and immature parasympathetic modulation. For a 28-week fetus, a baseline between 150-170 bpm may fall within the upper normal/mild tachycardic range.

Before classifying fetal tachycardia, recommended by AWHONN and Simpson, clinicians must first assess maternal contributors:

- * Fever
- * Tachycardia
- * Infection
- * Dehydration
- * Medications (e.g., beta-agonists)
- * Anxiety

This matches NCC's required first-line action: evaluate maternal status before escalating fetal assessment.

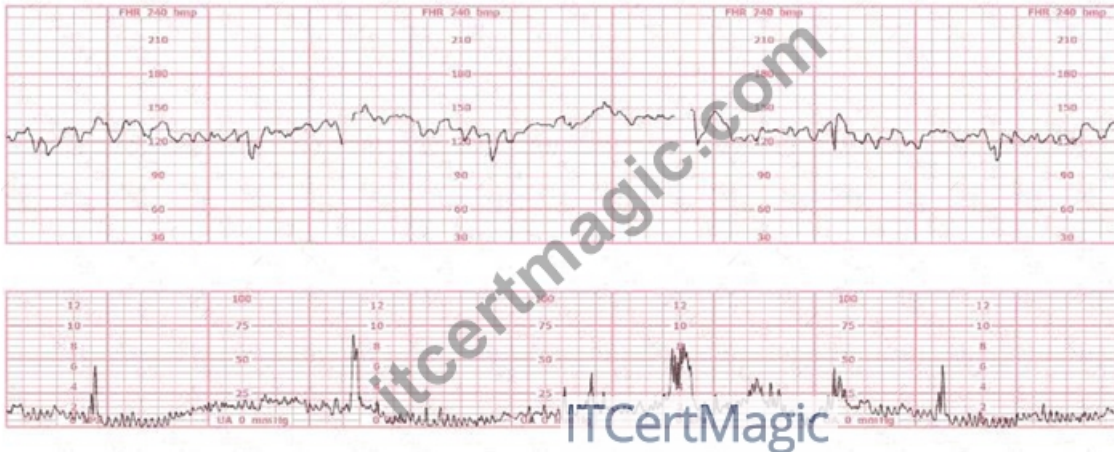
A biophysical profile (BPP) is not the immediate next step unless maternal status and fetal environment do not explain the finding.

Continuing observation without maternal evaluation is contrary to perinatal safety standards.

References: AWHONN Fetal Monitoring Principles Simpson & Miller Fetal Monitoring Menihan EFM Interpretation Guide NCC C-EFM Exam Content Domains 2025

NEW QUESTION # 38

A woman (G1P0) arrives in triage with a pain score of 4/10 at 39-weeks gestation. The fetal heart rate tracing shown is obtained. The best intervention is to:



- A. Discharge to home
- B. Admit for induction
- C. Adjust tocotransducer and continue to monitor

Answer: C

Explanation:

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

This tracing demonstrates a normal, reassuring fetal heart pattern that is technically categorized as Category I, indicating normal fetal acid-base status. Before any decision regarding discharge or induction, NCC emphasizes correct assessment of the tracing quality, fetal status, and uterine activity.

Key Tracing Characteristics

- * **Baseline:** Approximately 135-145 bpm, well within the normal range of 110-160 bpm.
- * **Variability:** The strip shows moderate variability (6-25 bpm), the strongest indicator of adequate fetal oxygenation per NCC, AWHONN, and NICHD.
- * **Accelerations:** Several accelerations are present—another reassuring feature of normal fetal well-being.
- * **Decelerations:** No variable, late, or prolonged decelerations are present.
- * **Uterine Activity:** The lower channel shows poor recording quality and inconsistent signal—suggesting the toco is not capturing contractions well, not that the patient is contracting excessively or not at all.

Correct interpretation per NCC:

NCC emphasizes distinguishing between physiologic assessment and technical artifact.

The fetal tracing is completely reassuring.

The only abnormality is the poor uterine activity signal, a common triage occurrence due to:

- * Toco placement
- * Maternal body habitus
- * Positioning
- * Low contraction intensity in early labor

Thus, the correct next step is to optimize equipment (reposition the toco, adjust belt, palpate contractions) and continue to monitor.

Why the other options are incorrect:

B). Admit for induction - NOT indicated

- * There is no evidence of fetal compromise.
- * No indication for induction is present (pain score 4/10, reassuring FHR, term pregnancy).
- * NCC emphasizes avoiding unnecessary interventions.

C). Discharge to home - NOT yet appropriate

- * You cannot safely discharge a patient with a poorly monitored contraction pattern.
- * Adequate assessment requires confirming uterine activity—after fixing the toco.

Therefore, the appropriate action is:

A). Adjust tocotransducer and continue to monitor.

References: NCC C-EFM Candidate Guide (2025); NCC Content Outline; AWHONN Fetal Heart Monitoring Principles & Practices; NICHD Definitions; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 39

When accelerations precede a variable deceleration pattern, this is caused by

- A. oligohydramnios
- B. hypoxic reflex response
- C. occlusion of the umbilical vein

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (No URLs or Links) NCC-recommended physiologic texts (AWHONN, Menihan, Simpson, Creasy & Resnik) explain that variable decelerations are caused by umbilical cord compression.

This process occurs in a three-step sequence, well known in fetal monitoring physiology:

- * Umbilical vein occlusion occurs first # decreases fetal venous return # brief fetal acceleration (a compensatory sympathetic response).
- * Umbilical artery occlusion follows # increases fetal systemic vascular resistance # variable deceleration as vagal stimulation lowers the fetal heart rate.
- * Release of compression # post-deceleration acceleration may occur.

Thus, an acceleration immediately before a variable deceleration represents the initial compression of the umbilical vein, not a hypoxic response. This is a normal physiologic response to transient cord compression, often described in AWHONN and Menihan's physiologic explanation of "shoulders" around variable decelerations.

Oligohydramnios can contribute to cord compression but does not explain accelerations preceding the deceleration. A "hypoxic reflex" would not produce a pre-deceleration acceleration.

Therefore, the correct physiologic cause is:

Umbilical vein occlusion.

References (No URLs)

- * NCC C-EFM Candidate Guide 2025 - Physiology
- * AWHONN Fetal Heart Monitoring Principles
- * Menihan: Electronic Fetal Monitoring
- * Simpson & Creehan: Perinatal Nursing
- * Creasy & Resnik: Maternal-Fetal Medicine

NEW QUESTION # 40

The tracing shown is from a woman at 28-weeks gestation in the post-anesthesia care unit (PACU) after an appendectomy. She is alert and awake. Based on this fetal heart rate pattern, the most appropriate intervention is:



- A. Perform cesarean birth
- B. Continued monitoring
- C. Administer terbutaline

Answer: B

Explanation:

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

The fetal heart rate tracing shows:

- * Baseline around 140 bpm
- * Minimal variability
- * No accelerations
- * No decelerations
- * Regular uterine activity but not tachysystole

This pattern is Category II, but in the context of:

* 28-week gestation

* Immediate postoperative status after anesthesia

* Maternal alertness and stability

NCC and AWHONN emphasize that maternal sedation, post-anesthesia effects, medications, and physiologic stress commonly cause temporary minimal variability without acidemia, especially at preterm gestations where baseline variability is normally lower.

Key NCC principle:

Minimal variability in a stable mother without decelerations does NOT require emergent delivery.

Instead, the fetus should be observed as anesthesia effects wear off.

Why other answers are incorrect:

* A. Terbutaline - No tachysystole and no recurrent decels are present.

* C. Cesarean birth - No bradycardia, no late decels, no absent variability, and no Category III criteria.

Thus, appropriate management is B. Continued monitoring.

References: NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan EFM; Miller's Pocket Guide; NICHD Definitions; Creasy & Resnik.

NEW QUESTION # 41

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