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EFM practice test exam Questions with Answer 2023-2024

What FHR finding is top priority for immediate interventions?

- a. heart block rate of 60 bpm
- b. bradycardia
- c. tachycardia with minimal variability rate of 170 with pushing - answers>>B. BRADYCARDIA

The change from moderate to minimal variability which is most concerning would be when:

- a. association with tachysystole with or without pitocin
- b. association after giving stadol and phenergan
- c. association with active phase of pushing +3 station - answers>>a. association with tachysystole with or without pitocin

Explain the difference between "shoulders" and "overshoots" associated with variable decels (not approved NICHD approved terminology)

- a. shoulders are associated with moderate variability
- b. over shoots are associated with moderate variability
- c. shoulders are associated with minimal variability and overshoots are associated with absent variability - answers>>a. shoulders are associated with moderate variability

Define tachysystole with pitocin:

- a. tachysystole is > or equal to 5 contractions in 10 minutes averaged over a 30-minute time frame but only with fetal intolerance
- b. tachysystole is > or equal to 5 contractions in 10 minutes averaged over a 30-min time despite fetal intolerance of pattern, category 1 tracing
- c. tachysystole is >5 contractions in 10 minutes averaged over a 30-min period of time - answers>>c. tachysystole is >5 contractions in 10 minutes averaged over a 30-min period of time

What category tracing is baseline rate of 120, absent variability and prolonged 5-minute decel to the 60s?

- a. cat 1

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q69-Q74):

NEW QUESTION # 69

Nonstress testing is used more frequently for antepartum testing than contraction stress testing because contraction stress testing has a:

- A. Low predictability of fetal well-being within 7 days of a negative test
- B. Limited reporting option for the compromised fetus
- C. Higher frequency of equivocal test results

Answer: C

Explanation:

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

NCC and AWHONN explain that Contraction Stress Testing (CST):

- * Has a higher rate of equivocal ("equivocal-suspicious" or "equivocal-hyperstimulation") results
- * Frequently must be repeated or replaced with other tests
- * Requires inducing contractions, which carries risk (hyperstimulation, preterm labor, uterine rupture in scarred uterus) NST is used more commonly because it is:
 - * Noninvasive
 - * Easier to perform
 - * Has fewer contraindications
 - * Has a lower rate of equivocal results

Why the others are incorrect:

- * B - CST does detect fetal compromise reliably and is NOT limited in its reporting structure.
- * C - A negative CST actually has very high negative predictive value for 7 days, making this answer incorrect.

Thus the correct choice is A. Higher frequency of equivocal results.

References: NCC C-EFM Candidate Guide; AWHONN; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 70

A woman at 36-weeks gestation comes in because of uterine contractions radiating to the back. She has no insurance. In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), she is obligated to be:

- A. Stabilized and receive a medical screening examination
- B. Admitted without delay
- C. Transferred to a safety-net hospital

Answer: A

Explanation:

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

NCC's Professional Issues domain includes EMTALA obligations for pregnant patients. EMTALA requires that ANY individual who presents to a hospital emergency department-regardless of insurance status- must receive:

- * A Medical Screening Examination (MSE)
- * Stabilization of any identified emergency medical condition (including labor)
- * No transfer unless the patient requests it or the hospital cannot provide necessary stabilizing care This patient reports contractions at 36 weeks, which qualifies as a potential emergency medical condition until ruled out by the medical screening exam

Correct obligations per EMTALA:

- * She must NOT be transferred solely due to lack of insurance (option C).
- * She does NOT need to be admitted unless labor is confirmed (option A).
- * She must receive a medical screening examination and stabilization (option B).

Thus, the correct answer is B. Stabilized and receive a medical screening examination.

References: NCC C-EFM Candidate Guide (Professional Issues); EMTALA Statutory Requirements; AWHONN Fetal Heart Monitoring Principles & Practices.

NEW QUESTION # 71

Maternal-fetal exchange during labor is diminished by:

- A. An increase in maternal cardiac output
- B. Open-glottis pushing in second stage
- C. Placental calcifications

Answer: C

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Placental calcifications:

- * Reduce surface area for maternal-fetal gas exchange
- * Impair placental perfusion
- * Are associated with post-dates and chronic insufficiency
- * Decrease the placenta's ability to oxygenate the fetus

Why the incorrect answers are wrong:

- * A. Increased maternal cardiac output # improves uteroplacental perfusion.
- * B. Open-glottis pushing # improves oxygenation compared with closed-glottis Valsalva pushing.

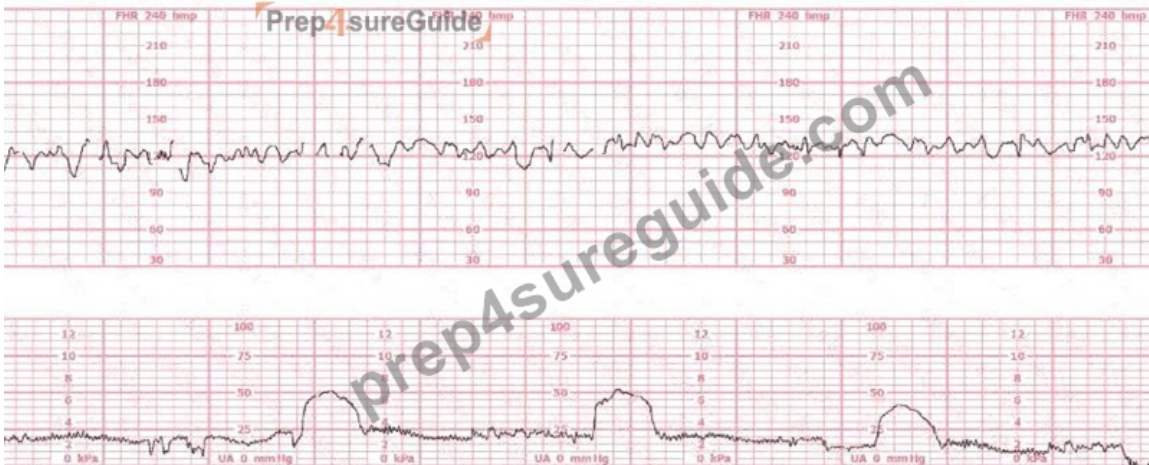
Correct answer: Placental calcifications.

References: NCC Physiology Domain; Creasy & Resnik; Simpson & Creehan; AWHONN FHMP.

NEW QUESTION # 72

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. present 10×10
- C. absent

Answer: B

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 # 73

A woman in active labor at 8 cm experiences spontaneous rupture of membranes and acute bright red vaginal bleeding. The uterus is soft and nontender to palpation. The fetal monitor tracing has been normal and now shows tachycardia followed by bradycardia with minimal variability. The maternal blood pressure is 130/76 mm Hg, and the pulse is 86 beats per minute. The most likely cause of these findings is:

- A. Abruptio placenta
- B. Placenta previa
- C. Ruptured vasa previa

Answer: C

Explanation:

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

When bright red vaginal bleeding occurs at the moment of membrane rupture, accompanied by an acute, severe fetal heart rate deterioration, NCC sources emphasize considering conditions causing fetal hemorrhage rather than maternal instability.

The key features in this scenario:

- * Timing: Bleeding occurs immediately with spontaneous rupture of membranes—this is classic for vasa previa rupture, where fetal vessels traverse membranes and are torn when the membranes rupture.
- * Bleeding characteristics: Bleeding is acute, bright red, and sudden. In vasa previa, the blood observed vaginally is fetal blood, not maternal blood.
- * Uterine exam: The uterus is soft and nontender, which strongly argues against abruptio placenta, where the uterus is typically firm, rigid, or painful.
- * Maternal vital signs: Maternal blood pressure and pulse are normal, indicating no maternal hypovolemia. In placental abruption or placenta previa with significant maternal bleeding, maternal vitals are often abnormal. Here, the mother is stable, meaning the blood is not maternal-supporting fetal vessel rupture.
- * Fetal heart rate pattern:
 - * Initial tachycardia, followed by
 - * Bradycardia with minimal variability. Such a pattern is consistent with acute fetal blood loss, which rapidly leads to fetal hypovolemia and hypoxia.
- * Differential based on NCC-aligned physiology:

A). Abruptio placenta - NOT supported

Typically presents with:

- * Painful bleeding
- * Firm, tender uterus
- * Maternal tachycardia
- * Uterine irritability. None of these are present.

B). Placenta previa - NOT supported

Classically painless bright red bleeding before or early in labor, not triggered by membrane rupture.

Fetal compromise is less sudden unless maternal shock occurs, which is not the case here.

C). Ruptured vasa previa - CORRECT

Defined by:

- * Painless, sudden bright red bleeding at ROM
- * Normal maternal vital signs
- * Rapid fetal deterioration (tachycardia # bradycardia # minimal variability)

* Soft, nontender uterus This fits the scenario exactly.

Therefore, the most likely cause is ruptured vasa previa, a recognized obstetric emergency described across AWHONN, NCC C-EFM references, and maternal-fetal physiology texts such as Menihan and Creasy & Resnik.

References: NCC C-EFM Candidate Guide (2025); NCC Content Outline; 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 # 74

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