

# Actual EFM Exam Questions - EFM Free Demo & EFM Valid Torrent

## EFM practice test

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 - ANSB. 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 - ANSa. 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 - ANSa. 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 - ANSc. 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
- b. cat 2
- c. cat 3 - ANScat 2

as the labor nurse is setting up for vacuum assisted or forcep assisted delivery by the provider, the stimulation of the \_\_\_\_\_ nerve occurs which results in fetal heart characteristic of

- a. vagus, tachycardia and minimal variability
- b. vagus, bradycardia
- c. trigeminal, minimal variability and an arrhythmia - ANSb. vagus, bradycardia

which tracing reveals the highest indicator for potential fetal acidemia?

- a. recurrent late decelerations with minimal variability, baseline rate of 115 bpm
- b. bradycardia with minimal variability, baseline rate of 85 bpm

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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q66-Q71):

### NEW QUESTION # 66

A fetal heart rate deceleration that is episodic is a/an:

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

**Answer: A**

Explanation:

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

NCC and NICHD differentiate:

- \* Periodic decelerations - those occurring with contractions
- \* Episodic decelerations - those occurring independent of contractions

Deceleration types:

- \* Early - periodic (mirror contractions)
- \* Late - periodic (after peak of contraction)
- \* Variable - may be periodic or episodic, and are the only type strongly associated with episodic patterns\*\* Therefore, the only deceleration type that is characteristically episodic is a variable deceleration.

Correct answer: C. Variable deceleration

References: NICHD FHR Definitions; NCC C-EFM Guide; AWHONN; Menihan; Simpson & Creehan.

### NEW QUESTION # 67

What is the appropriate interpretation of this tracing?



- A. Marked variability
- B. Tachycardia with variable decelerations
- C. Multiple prolonged accelerations

**Answer: A**

Explanation:

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

The tracing demonstrates:

- \* Baseline ~150 bpm
- \* Variability # 25 bpm amplitude, highly erratic and wide
- \* No sustained decelerations
- \* No sustained accelerations # 2 min

NICHD/NCC definition of marked variability:

Amplitude of baseline FHR fluctuations greater than 25 bpm.

Marked variability often reflects transient fetal autonomic instability due to:

- \* Fetal stimulation
- \* Mild hypoxemia
- \* Maternal anxiety
- \* Drugs (e.g., butorphanol)

Why other answers are incorrect:

- \* B. Multiple prolonged accelerations - No accelerations of #2 minutes are present.
- \* C. Tachycardia with variables - Baseline is NOT tachycardic (>160 bpm), and decelerations are not present.

Thus, the correct interpretation is A. Marked variability.

References: NICHD FHR Definitions; NCC C-EFM Candidate Guide; AWHONN; Menihan; Simpson & Creehan.

### NEW QUESTION # 68

Tachysystole can have a negative effect on fetal oxygenation during labor by

- A. interfering with reperfusion of the intervillous space
- B. increasing maternal blood pressure
- C. blocking active transport of oxygen to the fetus

**Answer: A**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources NCC-recommended physiology references (AWHONN, Simpson & Creehan, Menihan, Creasy & Resnik) consistently state that the primary mechanism by which tachysystole affects fetal oxygenation is reduced uteroplacental perfusion, specifically through impaired intervillous space reperfusion. During a normal contraction cycle, the fetus receives oxygen between contractions, when the uterus relaxes and maternal blood re-enters the intervillous space. AWHONN's Fetal Heart Monitoring Principles & Practices explains that tachysystole-defined as more than five contractions in 10 minutes averaged over 30 minutes-shortens or eliminates the relaxation phase, preventing adequate placental reoxygenation.

Simpson & Creehan highlight that "tachysystole decreases uteroplacental blood flow and interferes with replenishment of oxygenated maternal blood in the intervillous space." Menihan emphasizes that fetal hypoxemia in tachysystole results from interrupted perfusion, not from altered oxygen transport or maternal hemodynamic changes. Creasy & Resnik confirm that uterine overactivity reduces intervillous perfusion during contractions and impairs fetal oxygen exchange.

Thus, the physiologic problem is failure of the intervillous space to reperfuse, which compromises fetal oxygenation.

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 # 69

(Full question statement)

Recurrent decelerations are defined as occurring with 50% or more of contractions in any window of how many minutes?

- A. 0
- B. 1
- C. 2

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Without Links:

According to the NCC C-EFM Content Outline and AWHONN Fetal Heart Monitoring Principles, recurrent decelerations are specifically defined as decelerations that occur with #50% of uterine contractions in a 20-30-minute window, but standardized interpretation guidelines used by NCC and ACOG categorize recurrent patterns based on any 30-minute evaluation period.

AWHONN (FHM 6th Ed.) explains that fetal heart patterns must be evaluated over "a sufficiently long segment, typically 30 minutes, to determine whether the pattern is intermittent or recurrent." Menihan & Simpson further emphasize that recurrent decelerations imply a persistent physiologic stressor, requiring systematic evaluation and intrauterine resuscitation. NCC's Candidate Guide ties this rule directly into categorization within Category II and III tracings. Therefore, 30 minutes is the correct standard evaluation interval for determining recurrence.

### NEW QUESTION # 70

The pattern on the fetal heart rate tracing shown is likely due to



- A. placental insufficiency
- B. fetal head compression
- C. umbilical cord compression

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Sources:

The tracing demonstrates an abrupt-onset, sharp, V-shaped deceleration, occurring simultaneously with or slightly after a contraction—classic for variable decelerations, which are caused by umbilical cord compression.

According to AWHONN Fetal Heart Monitoring Principles & Practices, variable decelerations are defined by:

\* "Abrupt decreases in FHR below baseline of at least 15 bpm, lasting at least 15 seconds and less than 2 minutes."

\* "Most commonly associated with umbilical cord compression, whether transient or recurrent." Physiology reference (Simpson & Miller, Pocket Guide):

\* Compression of the umbilical vein causes a brief acceleration.

\* Compression of the umbilical arteries triggers a vagal response, producing a rapid deceleration.

\* This creates the characteristic sharp 'V', 'U', or 'W' shape on the monitor.

Placental insufficiency (Choice B) produces late decelerations, which are gradual, not abrupt.

Fetal head compression (Choice A) produces early decelerations, which mirror contractions and have a gradual pattern.

Thus, the tracing is most consistent with variable decelerations caused by umbilical cord compression.

References: AWHONN Fetal Heart Monitoring Principles & Practices; Simpson - Fetal Monitoring; Menihan

- Electronic Fetal Monitoring; Miller's EFM Pocket Guide; NCC C-EFM Content Outline - Pattern Recognition Domain.

### NEW QUESTION # 71

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