

NCC Practice Test EFM Pdf Exam Pass at Your First Attempt | EFM: Certified - Electronic Fetal Monitoring

NCC EFM Exam Practice 2023-2024 Question And Answers

Oxygen is transferred from mom to fetus via the placenta through? (ANS-Passive (Simple) Diffusion

Intervillous space perfusion is dependent on? (ANS-Adequate Uterine Blood Flow

Maternal Fetal Exchange is best promoted by which maternal position? (ANS- Either Rt or Lt Lateral

What is transfer down the concentration gradient from higher to lower called? (ANS-Diffusion

The most likely physical rationale for recurrent late decels after epidural is? (ANS-Maternal Sympathetic

Blockade

Which FHR pattern would be anticipated when monitoring mono-mono twins? (ANS-Variable Decels

Fetus can survive in an environment w/ a PO2 equal to adult venous blood d/t? (ANS-increased O2

carrying capacity

Variable decels are mediated primarily by? (ANS-baroreceptors

The sympathetic branch of the ANS influences FHR to? (ANS-increase

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

NEW QUESTION # 85

An electronic fetal monitoring factor that best correlates with fetal well-being is:

- A. Presence of variability
- B. Absence of decelerations
- C. Baseline heart rate 140-150 bpm

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

The single best indicator of fetal oxygenation and neurologic integrity is:

* Moderate baseline variability

Variability reflects:

* Normal autonomic regulation

* Adequate fetal oxygenation

* Intact neurologic pathways

Absence of decelerations is helpful but not as predictive.

Baseline FHR (e.g., 140-150) is normal, but baseline alone does not confirm well-being.

Correct answer: C. Presence of variability

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

NEW QUESTION # 86

(Full question statement)

The fetal heart rate tracing shown is obtained upon the woman's admission to labor and delivery. This tracing is most consistent with what maternal condition?

□

- A. Eisenmenger's syndrome
- B. Sickle cell anemia
- C. Systemic lupus erythematosus

Answer: B

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC C-EFM sources: AWHONN, Miller's Pocket Guide, Menihan, Simpson, Creasy & Resnik, 2025 Candidate Guide) The tracing displays baseline fetal bradycardia, with a rate near 100 bpm, minimal variability, and preserved periodic response. According to AWHONN's Fetal Heart Monitoring Principles & Practices and Menihan's Electronic Fetal Monitoring, maternal conditions that reduce oxygen-carrying capacity- including maternal anemia-can lead to lower fetal oxygen delivery, prompting a fetal compensatory bradycardic baseline.

Creasy & Resnik's Maternal-Fetal Medicine notes that sickle cell anemia decreases maternal hemoglobin function even when maternal vital signs appear stable, reducing uteroplacental oxygen transport. Fetuses of mothers with sickling disorders may demonstrate lower resting fetal heart rates due to chronic mild hypoxemia.

Conversely, Eisenmenger's syndrome is associated with severe maternal cyanosis and high fetal mortality, often producing late decelerations and growth restriction rather than mild bradycardia. Systemic lupus erythematosus (SLE) is commonly associated with heart block (especially with anti-Ro/SSA antibodies), which is not displayed here, as true heart block presents with a fixed atrial-ventricular dissociation and FHR

< 60 bpm

Thus, based on fetal physiology and maternal disease correlations taught in NCC-recommended sources, the tracing is most consistent with maternal sickle cell anemia.

NEW QUESTION # 87

(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: A

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 $\geq 50\%$ 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 # 88

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

Answer: A

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 # 89

This is a tracing of a multiparous woman in the second stage of labor. The vertex is at +3 station. This pattern has continued for the last 20 minutes. She has been pushing for 2½ hours, and oxytocin is infusing at 12 milliunits/minute. Management should include

- A. preparing for operative vaginal birth
- B. preparing for cesarean birth
- C. increasing the oxytocin

Answer: A

Explanation:

Comprehensive and Detailed Explanation (From NCC C-EFM-Referenced Sources) According to NCC C-EFM content guidance and AWHONN Fetal Heart Monitoring Principles (2022), recurrent variable and late patterns in second stage with descent to +2/+3 station require consideration of expediting delivery, especially when maternal effort is prolonged and oxytocin augmentation is already present.

Menihan & Simpson emphasize that with prolonged second stage, continued pushing beyond 2-3 hours, and vertex at +3 station, the evidence-based next step is operative vaginal birth, provided prerequisites are met. Cesarean is not indicated when the fetal head is already low and deliverable vaginally.

AWHONN and Creasy & Resnik state that increasing oxytocin when facing fetal stress and prolonged second stage is contraindicated, because tachysystole worsens fetal oxygenation and increases risk of fetal compromise.

Exact Extract Concepts Referenced:

- "Expedited delivery is recommended when recurrent decelerations persist in second stage and the head is low enough for operative vaginal birth." (AWHONN Principles)
- "Oxytocin should be reduced or discontinued in the presence of nonreassuring patterns." (Simpson, Obstetric Interventions)
- "Operative vaginal delivery is appropriate with full dilation, engaged head, and prolonged second stage." (Menihan, Simpson; Creasy & Resnik)

NEW QUESTION # 90

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