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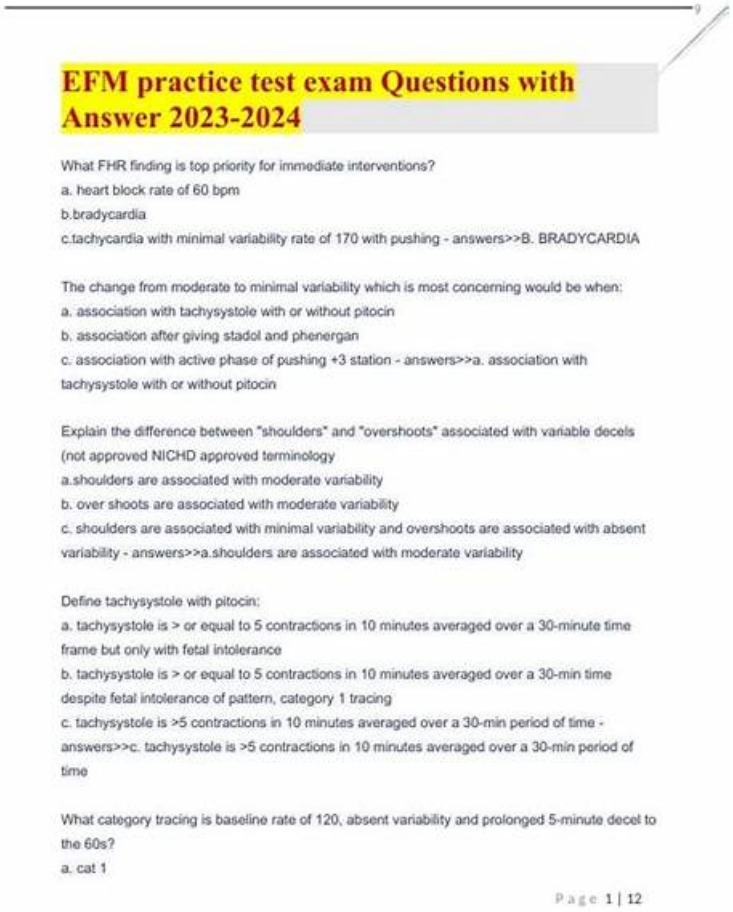

EFM practice test exam Questions with Answer 2023-2024

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

Page 1 | 12

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q64-Q69):

NEW QUESTION # 64
The tracing shown is a:

- A. Category III
- B. Category II
- C. Category I

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References (No URLs):
Interpretation of fetal heart rate (FHR) tracings in the NCC C-EFM exam follows the standardized NICHD three-tier classification, which is fully adopted in NCC's content outline and recommended references such as AWHONN Fetal Heart Monitoring Principles & Practices, Miller's EFM Pocket Guide, Menihan, Simpson' s Perinatal Nursing, and Creasy & Resnik.
Baseline:
The tracing demonstrates an FHR baseline around 145-150 bpm, which falls within the normal range of 110-160 bpm. NCC references define baseline as the mean FHR rounded to increments of 5 bpm over a 10-minute window.
Variability:
The strip shows minimal variability, with amplitude fluctuations approximately 0-2 bpm.
According to NCC-aligned definitions:
* Moderate variability: 6-25 bpm
* Minimal variability: 1-5 bpm
* Absent variability: undetectable amplitude
This tracing shows minimal variability, not moderate, so it cannot be Category I.
Accelerations:
No accelerations are present. Lack of accelerations alone does not classify the tracing as Category III.
Decelerations:
There are no recurrent late decelerations, no recurrent variable decelerations, and no prolonged decelerations. Without these, and with minimal variability, the tracing does not meet Category III criteria.
Category III criteria (per NICHD/NCC):
Must include at least one of the following:
* Absent variability with recurrent late decelerations
* Absent variability with recurrent variable decelerations
* Absent variability with bradycardia
* Sinusoidal pattern
None of these are present.
Category II criteria (per NICHD/NCC):
Category II includes tracings that are not Category I or III.
Examples specifically listed include:
* Minimal variability
* Absent accelerations after fetal stimulation
* Tachycardia
* Bradycardia without absent variability
* Variable or late decelerations occurring intermittently
Because this tracing shows minimal variability, a normal baseline, no accelerations, and no recurrent decelerations, it fits squarely into Category II.
Therefore, the correct classification is Category II.
References:NCC C-EFM Candidate Guide and Content Outline (2025); 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; NICHD Three-Tier FHR Interpretation System.

NEW QUESTION # 65
This tracing reflects:

- A. Category II
- B. Category I
- C. Category III

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
In NCC C-EFM interpretation, classification of a fetal heart tracing is based on NICHD's three-tier system:
Category I, II, and III. Category III represents an abnormal tracing requiring immediate evaluation and prompt intervention.
Key findings in this tracing:
* Baseline:Baseline is approximately 140 bpm, within the normal range (110-160 bpm).Baseline alone does not determine category.
* Variability:The tracing shows absent variability:
* No beat-to-beat oscillations
* Flat, minimal fluctuationNICHD and NCC define absent variability as amplitude range undetectable.
* Accelerations:No accelerations are present.
* Decelerations:The strip does not show decelerations or bradycardia.However, absent variability alone with no accelerations for 20 minutes is highly concerning.
Category Classification per NICHD/NCC:
Category III criteria include ANY of the following:
* Absent variability with recurrent late decelerations
* Absent variability with recurrent variable decelerations
* Absent variability with bradycardia
* Sinusoidal pattern
Also recognized as Category III:
* Persistent absent variability lasting #20 minutes with no accelerations, which is strongly suggestive of fetal acidemia when sustained.
This tracing shows:
* Absent variability (flat line)
* No accelerations
* Persisting over an extended period
Under NCC and AWHONN guidance:
A persistently flat tracing must be classified as Category III unless proven otherwise (e.g., fetal sleep, maternal medications), and it requires immediate intrauterine resuscitation and evaluation for potential expedited delivery.
Why Category I is NOT correct:
Category I requires:
* Moderate variability
* No late or variable decelerationsThis tracing does not have moderate variability.
Why Category II is NOT correct:
Category II includes minimal variability, marked variability, intermittent variables/lates, absence of accelerations after stimulation.
This tracing is worse than Category II because variability is absent, not minimal.
Thus, the tracing fits Category III.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Three-Tier FHR Interpretation System; 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 # 66
Maternal-fetal exchange during labor is diminished by:

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

Answer: A

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 FHMPP.

NEW QUESTION # 67
This tracing has lasted for 20 minutes in a woman who is 6 cm dilated. The most appropriate intervention is:

- A. Intravenous bolus of D5% Lactated Ringers
- B. Delivery
- C. Fetal scalp stimulation

Answer: C

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
This tracing shows:
* Baseline approximately 135-140 bpm
* Minimal variability
* No accelerations
* No recurrent decelerations
* Category II for 20 minutes
According to NCC, AWHONN, and NICHD, minimal variability persisting # 20 minutes without accelerations requires assessment of fetal acid-base status, and fetal scalp stimulation is an accepted method to evaluate fetal well-being when a Category II tracing persists.
Fetal scalp stimulation:
* Should produce an acceleration # 15 bpm lasting # 15 seconds
* A positive response indicates intact fetal nervous system and normal pH
* If no acceleration occurs # further intrauterine resuscitation or expedited delivery may be required Why other options are incorrect:
* A. Delivery - Not indicated; this is Category II, not Category III.
* C. IV bolus - IV hydration may improve variability, but assessment of fetal status comes first after
20 minutes of minimal variability.
Thus, the correct answer is B. Fetal scalp stimulation.
References:NCC C-EFM Candidate Guide; AWHONN FHMPP; NICHD Three-Tier System; Menihan; Miller's Pocket Guide; Simpson & Creehan.

NEW QUESTION # 68
(Full question statement)
A dysrhythmia is noted. The pregnancy and labor course has been normal with no complications. The next step in management is to

- A. continue to observe
- B. administer maternal oxygen
- C. start an IV fluid bolus

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (NCC C-EFM sources: AWHONN, Miller's Pocket Guide, Menihan, Simpson, Creasy & Resnik, 2025 Candidate Guide) AWHONN and Menihan emphasize that most fetal dysrhythmias detected intrapartum are premature atrial contractions (PACs)-the most common benign rhythm variation. They typically appear as intermittent, irregular deflections on the fetal heart rate tracing without affecting variability or baseline.
Miller's Pocket Guide to Fetal Monitoring states that PACs are usually transient, self-limiting, and require only observation unless accompanied by tachyarrhythmia or hemodynamic compromise. When variability is preserved and no repetitive pattern or sustained tachycardia occurs, no intrauterine resuscitation measures are indicated.
Simpson and Creehan describe that oxygen administration and fluid boluses are not recommended for benign dysrhythmias, as they do not improve fetal conduction patterns and may contribute to unnecessary interventions.
The NCC 2025 Candidate Guide specifies that correct management requires distinguishing benign arrhythmias from pathologic tachyarrhythmias, which would require escalation. In the absence of fetal compromise or maternal pathology, the appropriate action is continued observation.
Therefore, the correct management is to continue to observe.

NEW QUESTION # 69

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