

# Exam EFM Questions Fee, Training EFM For Exam

## 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 (Q116-Q121):

### NEW QUESTION # 116

Fetal cardiac output is essentially dependent on the fetal:

- A. Heart rate
- B. Activity
- C. Baroreceptors

**Answer: A**

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Because the fetal myocardium is immature, it has:

- \* Limited ability to increase stroke volume
- \* Limited ability to increase contractility

Therefore, fetal cardiac output (CO) is almost entirely dependent on heart rate.

NCC and AWHONN physiology describe:

- \*  $CO = \text{stroke volume} \times \text{heart rate}$
- \* In the fetus, stroke volume is relatively fixed
- \* Therefore, changes in HR directly affect cardiac output
- \* Tachycardia # increases CO
- \* Bradycardia # decreases CO # decreased perfusion and oxygen delivery

Why the other options are incorrect:

- \* A. Activity does not fundamentally determine CO.
- \* B. Baroreceptors regulate HR reflexively but are not the primary determinant of cardiac output.

Correct answer: C. Heart rate

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

### NEW QUESTION # 117

The decelerations seen in the fetal monitoring tracing shown are best described as:

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

**Answer: C**

Explanation:

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

Accurate classification of decelerations requires evaluating their shape, onset, nadir, recovery, relationship to contractions, and variability characteristics. NCC uses the NICHD standardized definitions, reinforced across AWHONN, Miller's Pocket Guide, Menihan, Simpson, and Creasy & Resnik.

Key features in this tracing:

- \* Abrupt onset The FHR drops rapidly from baseline to nadir in less than 30 seconds-this is the defining hallmark of a variable deceleration per NICHD.
- \* Sharp V-shape and deep amplitude The tracing shows steep descents and ascents, characteristic of cord compression-type variable decelerations.
- \* Inconsistent timing with contractions The decelerations do not begin at the start of contractions (as early decelerations would) and do not consistently begin after the peak of contractions (as late decelerations would). Variable decelerations can occur before, during, or after a contraction-exactly what is demonstrated here.
- \* Rapid return to baseline Another core feature of variable decelerations in NICHD/NCC definitions.
- \* No uniform contraction relationship Early decelerations are symmetrical and mirror contractions. Late decelerations begin after the peak of the contraction. This strip does not match either pattern.

Differentiation per NCC-aligned definitions:

- \* Early Decelerations: Gradual onset (>30 sec), nadir mirrors contraction peak, shallow, uniform. Not present.
- \* Late Decelerations: Gradual descent, nadir after contraction peak, smooth shape. Not present.

\* Variable Decelerations: Abrupt onset (<30 sec), variable timing, sharp V-shape, rapid recovery, often with shoulders. Exactly matches the tracing

Therefore, according to NICHD/NCC criteria, the decelerations shown are variable decelerations.

References: NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Standardized Definitions; 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 # 118

When documenting the occurrence of late decelerations in the medical record, what should be charted?

- A. Notation that the tracing was normal or abnormal
- B. Tracing category
- C. Components of the tracing

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

According to NCC, AWHONN, and evidence-based documentation standards, clinicians must document:

- \* Baseline
- \* Variability
- \* Accelerations
- \* Decelerations (type, depth, duration, timing)
- \* Uterine activity

This fulfills the NICHD 3-tier system and legal documentation expectations.

Why the incorrect answers are wrong:

- \* B. "Normal/abnormal" # vague, not an acceptable documentation standard.
- \* C. Category alone # insufficient; categories must be supported by the components.

References: NCC C-EFM Candidate Guide; AWHONN Documentation Standards; Menihan.

### NEW QUESTION # 119

A woman at 39-weeks gestation is in early labor, 2-3 cm dilated, 85% effaced, and -2 station. Based on the fetal heart rate tracing shown, what is the most appropriate first intervention?



- A. Adjust the fetal monitor
- B. Administer an IV fluid bolus
- C. Administer terbutaline

**Answer: A**

Explanation:

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

The tracing shows significant artifact, periods of signal loss, and abrupt changes inconsistent with physiologic fetal patterns. This is typical of poor signal quality, not actual fetal decelerations. In early labor at -2 station, external FHR monitoring often loses contact

due to fetal position and maternal movement.

NCC and AWHONN emphasize the following when artifact is present:

- \* Correct signal quality before interpreting the tracing.
- \* Troubleshooting steps include:- Adjusting transducer location- Ensuring adequate ultrasound gel- Repositioning the mother- Checking for maternal heart rate contamination Why the other options are incorrect:
- \* B. IV fluid bolus - Indicated for hypotension or late decelerations, not for artifact.
- \* C. Terbutaline - Used for tachysystole with fetal intolerance; there is no tachysystole shown.

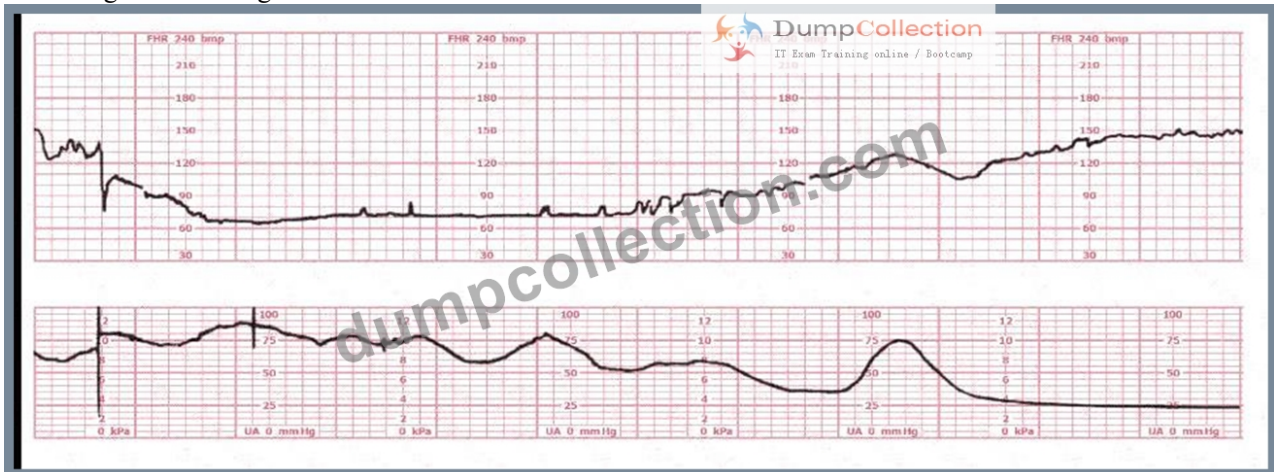
Thus, the correct first step is A. Adjust the fetal monitor.

References:NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; Miller' s Pocket Guide; Menihan; Simpson & Creehan.

## NEW QUESTION # 120

(Full question)

This tracing would be categorized as a



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

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (No URLs):

According to AWHONN Fetal Heart Monitoring Principles & Practice, Simpson & Miller, and the NCC C-EFM Content Outline, fetal heart rate categories are assigned based on baseline, variability, presence /absence of accelerations, and type of decelerations.

A Category II tracing includes any pattern that is not clearly normal (Category I) or clearly abnormal (Category III). Classic Category II features include:

- \* Bradycardia NOT accompanied by absent variability
- \* Tachycardia
- \* Minimal variability
- \* Marked variability
- \* Absence of accelerations after stimulation
- \* Recurrent variable decelerations with minimal or moderate variability
- \* Prolonged decelerations (#2 min but <10 min)

In this tracing, the fetus demonstrates:

- A prolonged deceleration with subsequent recovery,
- Presence of baseline variability,
- Return toward baseline but not immediately normal.

AWHONN and Simpson state that any prolonged deceleration automatically places the tracing in Category II unless variability is absent (which would escalate it to Category III). Because variability is present, it cannot be Category III.

Therefore, by NCC standards, this tracing is Category II.

## NEW QUESTION # 121

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