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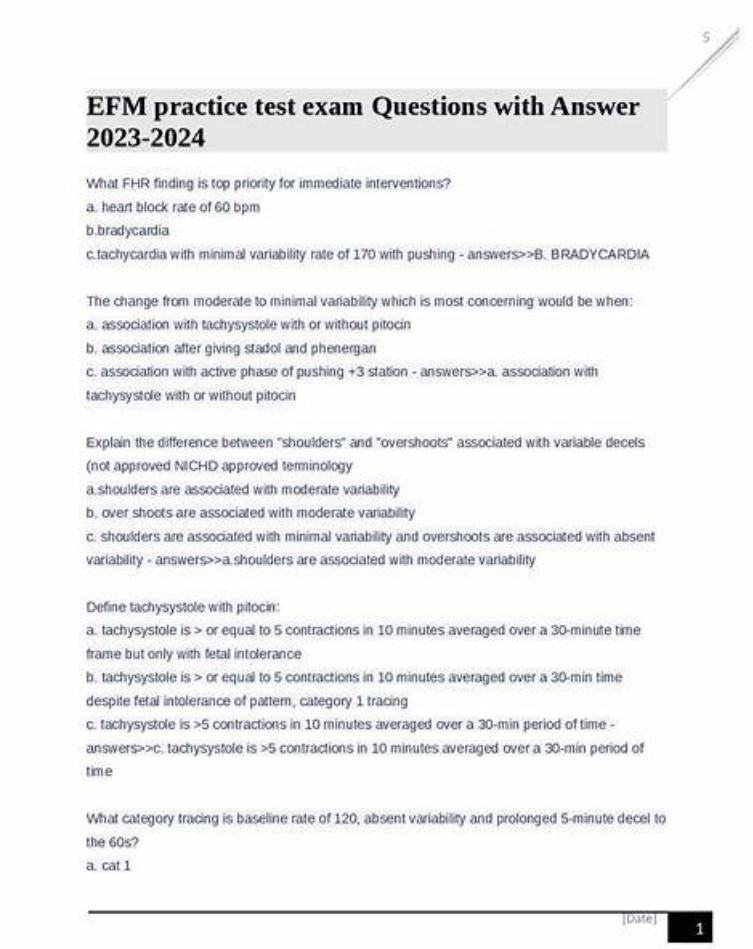

EFM practice test exam Questions with Answer 2023-2024

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 (Q14-Q19):

NEW QUESTION # 14
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 # 15
The most common fetal heart rate pattern consistent with uterine rupture is

- A. prolonged and variable decelerations
- B. absent variability
- C. loss of uterine pressure

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) According to AWHONN, Simpson, and NCC C-EFM physiologic competencies, uterine rupture commonly presents with:
* Sudden prolonged deceleration
* Recurrent variables
* Fetal bradycardia
* Possible loss of station, vaginal bleeding, maternal pain
AWHONN specifically lists:
"Prolonged deceleration is the most common initial fetal sign of uterine rupture." Absent variability can occur later, but it is not the most common initial pattern.
"Loss of uterine pressure" refers to loss of toco signal, not a fetal heart rate characteristic.
Therefore, NCC-validated interpretation: prolonged and variable decelerations.

NEW QUESTION # 16
This is a fetal heart rate tracing of a multiparous woman whose cervix is 7 cm dilated on admission. The most likely cause for this pattern is:

- A. Placental abruption
- B. Rapid fetal descent

- C. Tachysystole

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The tracing shows a clear relationship between uterine activity and fetal heart rate changes:
* The uterine activity strip demonstrates very frequent contractions with little resting time between them, exceeding five contractions in 10 minutes, averaged over a 30-minute window.
* NCC and NICHD define tachysystole as "more than 5 contractions in 10 minutes, averaged over 30 minutes, regardless of whether the labor is spontaneous or stimulated." As uterine activity intensifies and becomes excessively frequent, the fetal heart rate strip begins to show:
* Progressive decrease in baseline
* Recurrent decelerations with gradual onset and recovery
* Reduced variability in the latter portion of the strip
This pattern is consistent with uteroplacental insufficiency caused by excessive uterine activity (tachysystole). NCC and AWHONN emphasize that tachysystole can result in decreased uterine blood flow and fetal oxygenation, leading to late or prolonged decelerations and eventual bradycardia if not corrected.
Why the other options are less likely:
* A. Placental abruptionTypically associated with maternal symptoms (pain, vaginal bleeding, firm /boardlike uterus) and often a sustained increase in resting tone or a hypertonic contraction, not simply very frequent contractions. These maternal findings are not described in the vignette.
* B. Rapid fetal descentUsually causes variable or early decelerations related to head compression, but the tocodynamometer would not necessarily show this degree of contraction frequency. The lower strip here clearly highlights excessive contractions as the primary problem.
Thus, the tracing's FHR abnormalities are best explained by tachysystole, making C. Tachysystole the most appropriate answer.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline - Pattern Recognition and Intervention; 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 # 17
Fetal cardiac output is essentially dependent on the fetal:

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

Answer: B

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 = stroke volume × 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 # 18
This fetal heart rate pattern is classified as Category III based on:

- A. Contraction pattern
- B. Type of deceleration
- C. Absent variability

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
This tracing shows recurrent late decelerations accompanied by absent variability.
Per NICHD/NCC, a tracing is Category III if ANY of the following are present:
* Absent variability AND recurrent late decelerations
* Absent variability AND recurrent variable decelerations
* Absent variability AND bradycardia
* Sinusoidal pattern
In this strip:
* Variability is absent
* Decelerations are recurrent and late
The determining feature for the classification is absent variability, which indicates significant risk for fetal acidemia.
The contraction pattern (option B) does not determine category.
The deceleration type alone (option C) does not determine Category III without absent variability.
Thus, the classification is Category III because of absent variability.
References:NCC C-EFM Candidate Guide; NICHD Three-Tier System; AWHONN Fetal Heart Monitoring Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring.

NEW QUESTION # 19
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