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C-EFM Exam Questions and Answers Latest Update, A+ Guide

The paper speed used with EFM in North America is:
a. 1cm/min
b. 2cm/min
c. 3cm/min - C. 3cm/min

The US transducer on the EFM measures the
a. Electrical signal of the fetal heart
b. Mechanical movement of the fetal heart reflected off of sound waves
c. R to R intervals of the fetal heart - b. Mechanical movement of the fetal heart reflected off of sound waves

The purpose of the autocorrelation in external monitoring is to
a. Compare incoming waveforms for comparison
b. Decrease signal to noise levels
c. Distinguish fetal from maternal heart rate - a. Compare incoming waveforms for comparison

The area of maximum intensity of FHR is usually the fetal
a. Back
b. Chest
c. Umbilicus - a. Back

Palpating the uterus is best performed by using the
a. Back of hand
b. Fingertips
c. Palm - B. Fingertips

What is the most sensitive method of assessing uterine activity?
a. Intrauterine pressure catheter
b. Manual palpation

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q121-Q126):

NEW QUESTION # 121
The duration of a contraction is best represented by which colored arrow?

- A. Blue (A)
- B. Red (C)
- C. Green (B)

Answer: C

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
Contraction duration is defined as the length of time from the beginning of a contraction to the end of the same contraction (NICHD uterine activity definitions).
In the diagram:
* Green arrow (B) spans one individual contraction from rise # peak # return to baseline.
* Blue arrow (A) measures the interval between contractions (frequency).
* Red arrow (C) measures peak-to-peak amplitude shape, not duration.
Therefore, the green arrow correctly identifies contraction duration.
References:NCC Candidate Guide; AWHONN FHMPP; Menihan EFM; Simpson & Creehan.

NEW QUESTION # 122
(Full question statement)
The American College of Obstetricians and Gynecologists (ACOG) recommends continuous electronic fetal monitoring in pregnancies when there is:

- A. A history of preterm birth
- B. Maternal diabetes
- C. Macrosomia

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract Without Links:
NCC relies heavily on ACOG Practice Bulletins for risk-based monitoring decisions. ACOG identifies maternal diabetes (pregestational or poorly controlled gestational diabetes) as a key high-risk obstetric condition warranting continuous electronic fetal monitoring due to risks such as fetal hypoxia, macrosomia, and metabolic complications.
In contrast, a history of preterm birth does not necessarily require continuous monitoring unless current pregnancy complications are present.
Macrosomia alone does not automatically justify continuous EFM unless accompanied by other risk factors.
Therefore, according to NCC-aligned ACOG clinical criteria, maternal diabetes is the correct indication.

NEW QUESTION # 123
Maternal-fetal oxygen transfer takes place in the:

- A. Spiral arteries
- B. Umbilical vein
- C. Intervillous space

Answer: C

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Physiologic Sources:
Oxygen transfer occurs at the maternal-fetal interface within the intervillous space, where:
* Maternal blood from the spiral arteries bathes the chorionic villi
* Diffusion occurs between maternal blood and fetal capillary beds
* Oxygen then travels through fetal circulation via the umbilical vein
Thus:
* Intervillous space = site of gas exchange
* Spiral arteries = deliver maternal blood to that space

* Umbilical vein = fetal vessel carrying oxygenated blood after exchange has occurred Correct answer: A. Intervillous space
References:NCC Physiology Domain; AWHONN FHMPP; Creasy & Resnik; Simpson & Creehan.

NEW QUESTION # 124
Sustained fetal supraventricular tachycardia that goes untreated is most likely to result in:

- A. The need for a neonatal pacemaker
- B. Fetal anemia
- C. Hydrops fetalis

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Sustained fetal supraventricular tachycardia (SVT) often produces heart rates > 200-240 bpm, causing:
* Poor ventricular filling
* Decreased stroke volume
* Reduced cardiac output
* Congestive heart failure
* Progressive fluid accumulation
NCC and AWHONN emphasize that untreated SVT leads to hydrops fetalis, characterized by:
* Ascites
* Pleural effusion
* Pericardial effusion
* Skin edema
Why the other answers are incorrect:
* A. Fetal anemia - Causes tachycardia but is not caused by SVT.
* C. Neonatal pacemaker - Pacemakers treat heart block, not SVT.
Correct answer: B. Hydrops fetalis
References:NCC C-EFM Candidate Guide; AWHONN Principles & Practices; Simpson & Creehan; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 125
When a difference in interpretation occurs over a non-emergent electronic fetal heart rate tracing, the first step toward resolution is to:

- A. Document the incident in the medical record
- B. Follow the chain of command
- C. Have the involved clinicians review the tracing together

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC's Professional Issues domain emphasizes communication, collaboration, and team-based interpretation of electronic fetal monitoring tracings.
For non-emergent differences in interpretation, the first step is:
* Discussion and joint review of the tracing by the involved clinicians.
Only if disagreement persists should the chain of command be used. Documentation occurs after consensus or escalation-not as the first step.
Thus, the appropriate first step is C. Have the involved clinicians review the tracing together.
References:NCC C-EFM Candidate Guide; AWHONN Standards for Professional Fetal Monitoring Practice; TeamSTEPPS principles.

NEW QUESTION # 126
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