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NCC EFM Test With Correct Solutions 2024

Uterine contractions are quantified as - correct answer.the number of contractions present in a 10 min window

Normal frequency of uterine contractions - correct answer. ≤ 5 contractions in 10 min, averaged over a 30 min window

Tachysystole is - correct answer. >5 contractions in 10 min, averaged over a 30 min window. Should be qualified as to the presence or absence of FHR decelerations

Terms describing uterine contractions that have been abandoned - correct answer."hyperstimulation" and "hypercontractility"

FHR patterns are defined by the characteristics of - correct answer.baseline, variability, accelerations, and decelerations

Baseline FHR is determined by approximating the mean FHR rounded to increments of (A) bpm during a (B) min window, excluding (C) and (D) and periods of (E) FHR variability - correct answer.A. 5

- B. 10
- C. accelerations
- D. decelerations
- E. marked

There must be at least (A) minutes of identifiable baseline segments in any (B) minute window, or the baseline for that period is (C) - correct answer.A. 2

- B. 10
- C. Indeterminate

Bradycardia - correct answer.a baseline FHR <110

Tachycardia - correct answer.a baseline FHR >160

Baseline FHR variability is determined in a (A) min window excluding (B) and (C) - correct answer.A. 10

- B. accelerations
- C. decelerations

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q124-Q129):

NEW QUESTION # 124

The fetal heart rate tracing shown is consistent with

- A. half counting
- B. artifact
- C. supraventricular tachycardia

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources The tracing demonstrates a very rapid, highly regular baseline fetal heart rate with minimal beat-to-beat variability-characteristic of fetal supraventricular tachycardia (SVT). NCC-recommended references, including AWHONN's Fetal Heart Monitoring Principles & Practices, Menihan's Electronic Fetal Monitoring: Concepts and Applications, Simpson & Creehan's Perinatal Nursing, and Creasy & Resnik's Maternal-Fetal Medicine all describe fetal SVT as a sustained tachyarrhythmia usually greater than 200 bpm, narrow-complex, and extremely regular in appearance.

AWHONN teaches that SVT appears as a "tight, rapid, uniform baseline with minimal variability." Menihan states that "SVT may present on EFM as a nearly straight line due to the rapid, consistent rate with micro- oscillations." This differs significantly from artifact, which appears disorganized, erratic, and inconsistent in amplitude. Additionally, "half-counting" is a Doppler misinterpretation that records half of an extremely fast fetal rate, usually resulting in a falsely lower heart rate-not the very rapid tracing shown here.

Creasy & Resnik emphasize that SVT is the most common pathological fetal arrhythmia and can lead to fetal compromise if prolonged, making accurate recognition essential. Miller's Pocket Guide to Fetal Monitoring also identifies SVT as a pattern with a "smooth, fast rhythm lacking normal variability." All authoritative NCC-recommended references support that this EFM pattern is consistent with fetal SVT, not artifact or half-counting.

References:

AWHONN - Fetal Heart Monitoring Principles & Practices
Menihan - Electronic Fetal Monitoring
Simpson & Creehan - Perinatal Nursing
Creasy & Resnik - Maternal-Fetal Medicine
Miller's Pocket Guide to Fetal Monitoring

NEW QUESTION # 125

The most probable underlying fetal physiologic cause for this tracing would be

- A. Vagal nerve stimulation in response to hypoxemia
- B. Myocardial hypoxic depression
- C. Release of catecholamines

Answer: C

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

This tracing shows:

* Baseline ~145 bpm

* Minimal variability

* No accelerations or decelerations

* Very little fluctuation # resembles a flat/minimal variability Category II tracing The key physiologic mechanism behind minimal variability in the presence of a normal baseline and normal contraction pattern is most often:

Increased fetal sympathetic tone, driven by catecholamine release (epinephrine and norepinephrine).

NCC and AWHONN explain:

* Catecholamine release (due to fetal stress, early hypoxemia, or maternal stress) results in:

* Reduced beat-to-beat fluctuation

- * Minimal baseline variability
- * This is considered an early compensatory mechanism, not yet a decompensated hypoxic state.
- Why the other answers are incorrect:
- * A. Myocardial hypoxic depression
- * Causes absent variability, NOT minimal variability.
- * Represents advanced or severe hypoxia. The FHR here is not absent variability.
- * C. Vagal stimulation in response to hypoxemia
- * Produces decelerations, especially late or prolonged.
- * This strip shows no decelerations, ruling this out.

Therefore the most accurate physiologic explanation is B. Release of catecholamines.

References: NCC C-EFM Candidate Guide; AWHONN FHMPP; NICHD Baseline Variability Definitions; Menihan EFM; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 126

A sentinel or reportable event as defined by the Joint Commission or other regulatory bodies/agencies is one that

- A. requires investigation and response
- B. must involve malpractice or negligence
- C. requires mandatory education for providers

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Sentinel events are defined by the Joint Commission as unexpected occurrences involving death, serious physical or psychological injury, or the risk thereof, and they require immediate investigation, root-cause analysis, and institutional response. They do not require confirmed malpractice or negligence. AWHONN's perinatal safety guidelines and NCC's Professional Issues domain specify that sentinel events trigger mandatory reporting, analysis, system review, and corrective action plans. Simpson & Creehan emphasize that they are addressed through standardized safety processes, including interdisciplinary review.

Miller's Pocket Guide notes that sentinel events are "events that require immediate investigation to prevent recurrence," aligning with answer choice B.

References:

AWHONN - Perinatal Safety Guidelines
NCC - C-EFM Content Outline (Professional Issues)
Simpson & Creehan - Perinatal Nursing
Menihan - EFM Professional Standards Chapter
Miller's Pocket Guide

NEW QUESTION # 127

Tachysystole can have a negative effect on fetal oxygenation during labor by

- A. interfering with reperfusion of the intervillous space
- B. blocking active transport of oxygen to the fetus
- C. increasing maternal blood pressure

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources NCC-recommended physiology references (AWHONN, Simpson & Creehan, Menihan, Creasy & Resnik) consistently state that the primary mechanism by which tachysystole affects fetal oxygenation is reduced uteroplacental perfusion, specifically through impaired intervillous space reperfusion. During a normal contraction cycle, the fetus receives oxygen between contractions, when the uterus relaxes and maternal blood re-enters the intervillous space. AWHONN's Fetal Heart Monitoring Principles & Practices explains that tachysystole-defined as more than five contractions in 10 minutes averaged over 30 minutes-shortens or eliminates the relaxation phase, preventing adequate placental reoxygenation.

Simpson & Creehan highlight that "tachysystole decreases uteroplacental blood flow and interferes with replenishment of oxygenated maternal blood in the intervillous space." Menihan emphasizes that fetal hypoxemia in tachysystole results from interrupted perfusion, not from altered oxygen transport or maternal hemodynamic changes. Creasy & Resnik confirm that uterine overactivity reduces intervillous perfusion during contractions and impairs fetal oxygen exchange.

Thus, the physiologic problem is failure of the intervillous space to reperfuse, which compromises fetal oxygenation.

References:

AWHONN - Fetal Heart Monitoring Principles & Practices
Simpson & Creehan - Perinatal Nursing
Menihan

NEW QUESTION # 128

A fetal heart rate tracing is abnormal. A change in maternal position and oxygen administration do not correct the pattern. Following birth, a fetal cord blood sample is taken:

pH = 7.25

PaCO# = 46 mm Hg

PaO# = 20 mm Hg

HCO# = 22 mEq/L

Base deficit = -4 mEq/L

These results are best interpreted as:

- A. Normal
- B. Acidosis
- C. Hypoxia

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Normal umbilical arterial values per NCC/AWHONN/Menihan:

* pH: 7.20-7.30

* PaCO#: 45-55 mmHg

* HCO#: 20-24 mEq/L

* Base deficit: 0 to -5 (normal to mild respiratory changes)

This sample shows:

* pH 7.25 # normal

* Base deficit -4 # no metabolic acidosis

* HCO# normal

* Slightly elevated PaCO#, consistent with mild respiratory influence but still normal

* PaO# 20 mmHg is normal for cord arterial blood

This profile is not acidotic (acidosis requires pH <7.10 and base deficit #12).

It also does not indicate hypoxia, which would present with metabolic acidosis.

Therefore: Normal.

References: NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 129

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