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## NCC EFM Cert. Exam with Answers

Ductus venosus connects \_\_\_\_\_ to \_\_\_\_\_? - ✓ Umb. vein to IVC  
Foramen ovale connects \_\_\_\_\_ to \_\_\_\_\_? - ✓ R. atrium to L. atrium  
Ductus arteriosus connects \_\_\_\_\_ to \_\_\_\_\_? - ✓ Pulm. artery to aorta  
Normal rate - ✓ 110 to 160 BPM  
Average baseline rate at 15wks gestation - ✓ 160 BPM  
Average rate in fetus with heart block - ✓ 60 BPM (intrinsic ventricular or nodal rate)  
Sympathetic effects - ✓ Incr. HR, constricted peripheral and visceral blood vessels, vital organs dilate and receive more blood  
Gest. age at which autonomic nervous system is fully developed - ✓ ~ 32wks  
Primary indicator of fetal oxygenation - ✓ Presence or absence of variability  
Location of chemoreceptors - ✓ aortic arch  
Chemoreceptors respond to? - ✓ Changes in O<sub>2</sub> and CO<sub>2</sub>  
Location of baroreceptors - ✓ Aortic arch and carotid bodies  
Maximal reactivity occurs when? - ✓ Late at night  
Max duration of fetal nonreactivity? - ✓ 80min  
Sensitivity - ✓ Probability of detecting a true positive  
Specificity - ✓ Probability that true negative will be detected  
False positive - ✓ erroneously positive when reality is negative  
False negative - ✓ erroneously negative when reality is positive  
NST - ✓ Two 15x15 accels in 20min (up to 40min)  
% of false positive CSTs? - ✓ ~ 30%  
BPP components - ✓ 1) Fetal breathing movements

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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q50-Q55):

### NEW QUESTION # 50

Fetal respiratory acidosis is most likely to present with which of the following fetal heart rate decelerations?

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

**Answer: C**

Explanation:

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

NCC and AWHONN physiology teachings:

- \* Variable decelerations caused by cord compression lead to:
  - \* Transient interruption of umbilical venous flow
  - \* Impaired fetal gas exchange
  - \* Acute rise in CO<sub>2</sub>
  - \* Respiratory acidosis (early phase of hypoxemia)

This is well documented:

- \* Early decelerations # head compression # NOT associated with acidemia.
- \* Late decelerations # uteroplacental insufficiency # metabolic acidosis, not respiratory.

Thus:

- \* Variable decelerations # respiratory acidosis
- \* Late decelerations # metabolic acidosis

Correct answer: C. Variable

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

### NEW QUESTION # 51

The baseline heart rate of a 28-week fetus is 170 bpm. The next step is to:

- A. Perform a biophysical profile
- B. Continue observation
- C. Assess maternal vital signs

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Without Any URLs or Links:

NCC references (AWHONN, Simpson, Menihan) and the Physiology domain emphasize that baseline fetal heart rate is higher at earlier gestational ages due to predominant sympathetic tone and immature parasympathetic modulation. For a 28-week fetus, a baseline between 150-170 bpm may fall within the upper normal/mild tachycardic range.

Before classifying fetal tachycardia, recommended by AWHONN and Simpson, clinicians must first assess maternal contributors:

- \* Fever
- \* Tachycardia
- \* Infection
- \* Dehydration
- \* Medications (e.g., beta-agonists)
- \* Anxiety

This matches NCC's required first-line action: evaluate maternal status before escalating fetal assessment.

A biophysical profile (BPP) is not the immediate next step unless maternal status and fetal environment do not explain the finding. Continuing observation without maternal evaluation is contrary to perinatal safety standards.

References: AWHONN Fetal Monitoring Principles; Simpson & Miller Fetal Monitoring; Menihan EFM Interpretation Guide; NCC C-EFM Exam Content Domains 2025

### NEW QUESTION # 52

Based on the tracing shown, the first action should be to

- A. assess maternal temperature
- B. administer vibroacoustic stimulation
- C. palpate for contractions

**Answer: C**

Explanation:

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

According to the NCC C-EFM exam outline and AWHONN Fetal Heart Monitoring Principles (2022), the first step when evaluating a concerning fetal heart rate pattern is to verify uterine activity, because the fetal response is often directly associated with contraction frequency, strength, or tachysystole. AWHONN states that "the clinician must confirm maternal-fetal physiology and uterine activity by palpation when interpreting any FHR pattern, as tocodynamometry may under- or overestimate uterine pressure." Menihan's Electronic Fetal Monitoring further emphasizes: "Always validate the contraction pattern via maternal abdominal palpation before proceeding with additional interventions." The tracing shows a late-appearing deceleration pattern with uncertain contraction correlation because the external toco waveform is inadequate (flat or poorly recorded). Before determining whether the decelerations are early, late, or variable, the clinician must confirm whether contractions are present, absent, or excessive. This step is listed as a core competency under Pattern Recognition & Intervention in the NCC Candidate Guide.

Therefore, palpating for contractions is the required first intervention.

References:AWHONN Fetal Heart Monitoring (2022-2024 Edition)Menihan: Electronic Fetal MonitoringSimpson & Creasy: Perinatal Nursing / Maternal-Fetal PhysiologyNCC C-EFM Content Outline - Pattern Recognition and Intervention Domain

### NEW QUESTION # 53

A key differentiating factor when determining if a deceleration is early or late is the

- A. timing in relation to contractions
- B. onset to nadir
- C. depth of the deceleration

**Answer: A**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) AWHONN and Menihan clearly state that classification of decelerations is determined by their timing relative to uterine contractions:

\* Early decelerations: "mirror the contraction; onset, nadir, and recovery occur simultaneously with the contraction."

\* Late decelerations: "begin after the contraction begins and return to baseline after the contraction ends." Depth is not a differentiating feature, as both early and late decelerations may vary in depth. The onset-to- nadir interval is used to differentiate variable vs. early/late, not early vs. late.

Thus, timing relative to contractions is the correct NCC-supported answer.

### NEW QUESTION # 54

A 20-year-old woman (G1P0) at 40-weeks gestation was admitted for cervical ripening with dinoprostone (Cervidil) four hours ago. She developed the pattern shown one hour ago. She has been changed to a lateral position and given a fluid bolus, and the pattern continues. An appropriate intervention would be to:

- A. Continue to observe
- B. Remove the dinoprostone (Cervidil) insert
- C. Give 0.25 mg of terbutaline subcutaneously

**Answer: B**

Explanation:

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

The tracing shows tachysystole (more than 5 contractions in 10 minutes) with minimal variability and recurrent decelerations consistent with uteroplacental insufficiency caused by excessive uterine activity.

Dinoprostone (Cervidil) is a uterotonic prostaglandin, and one of its known complications is uterine tachysystole with Category II or III fetal heart rate patterns.

NCC/AWHONN guidance for tachysystole caused by prostaglandins:

\* FIRST intervention: Remove the dinoprostone insert.

\* Reposition the patient (already done).

\* IV fluid bolus (already done).

\* Consider terbutaline only if tachysystole persists after removal of the agent.

Since maternal repositioning and IV fluids have already failed, the next step is to remove the cervical ripening agent.

Why other answers are incorrect:

\* A. Continue to observe - Never acceptable with tachysystole + fetal intolerance.

\* B. Terbutaline - May be used after prostaglandin removal, not before.

Thus, the correct answer is C. Remove the dinoprostone insert.

References: NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan; Miller's Pocket Guide; NICHD Definitions; Creasy & Resnik.

## NEW QUESTION # 55

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