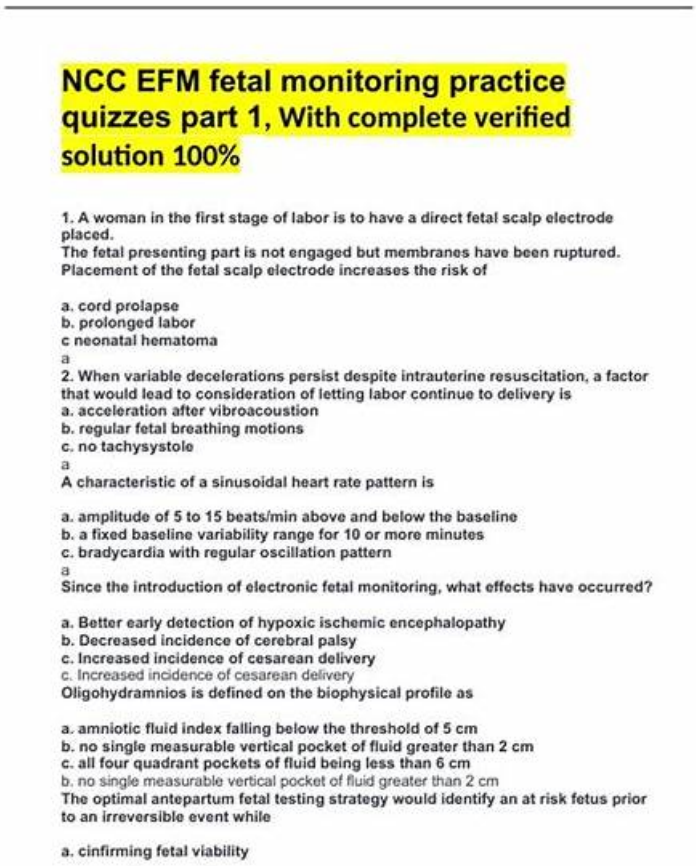
Free PDF Quiz 2026 NCC EFM: Certified - Electronic Fetal Monitoring Perfect Latest Braindumps Ppt



NCC EFM fetal monitoring practice quizzes part 1, With complete verified solution 100%

1. A woman in the first stage of labor is to have a direct fetal scalp electrode placed.
The fetal presenting part is not engaged but membranes have been ruptured.
Placement of the fetal scalp electrode increases the risk of

a. cord prolapse
b. prolonged labor
c neonatal hematoma
a
2. When variable decelerations persist despite intrauterine resuscitation, a factor that would lead to consideration of letting labor continue to delivery is
a. acceleration after vibroacoustion
b. regular fetal breathing motions
c. no tachysystole
a
A characteristic of a sinusoidal heart rate pattern is

a. amplitude of 5 to 15 beats/min above and below the baseline
b. a fixed baseline variability range for 10 or more minutes
c. bradycardia with regular oscillation pattern
a
Since the introduction of electronic fetal monitoring, what effects have occurred?

a. Better early detection of hypoxic ischemic encephalopathy
b. Decreased incidence of cerebral palsy
c. Increased incidence of cesarean delivery
c. Increased incidence of cesarean delivery
Oligohydramnios is defined on the biophysical profile as

a. amniotic fluid index falling below the threshold of 5 cm
b. no single measurable vertical pocket of fluid greater than 2 cm
c. all four quadrant pockets of fluid being less than 6 cm
b. no single measurable vertical pocket of fluid greater than 2 cm
The optimal antepartum fetal testing strategy would identify an at risk fetus prior to an irreversible event while

a. cinfirming fetal viability

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q60-Q65):

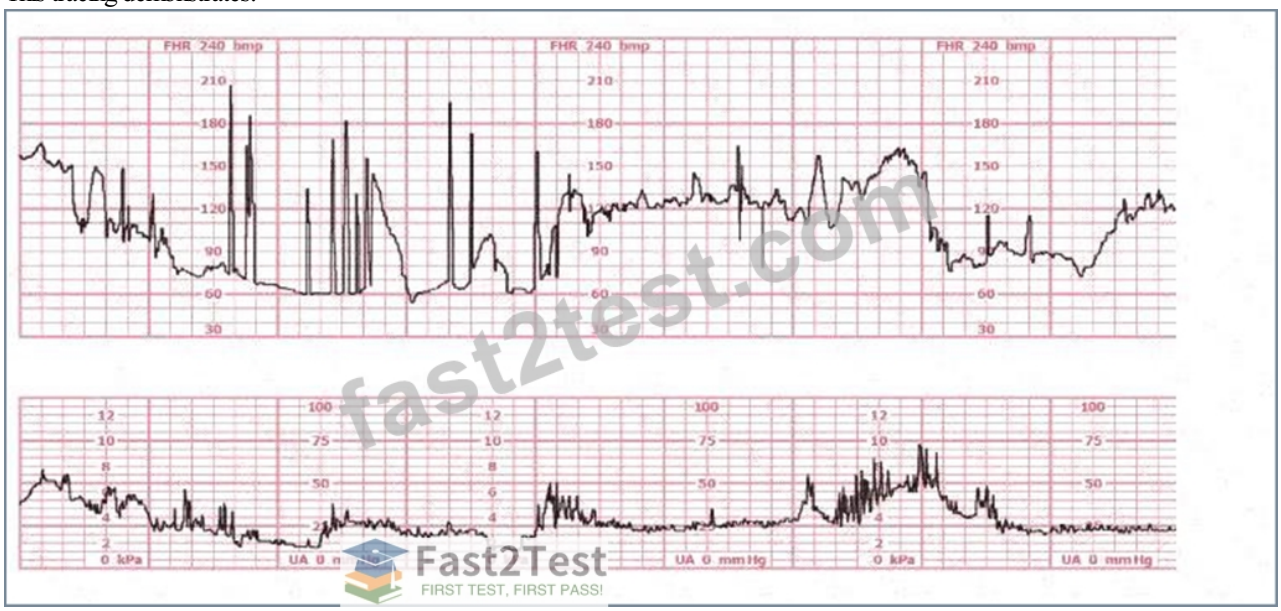
NEW QUESTION # 60
(Full question statement)
The American College of Obstetricians and Gynecologists (ACOG) recommends continuous electronic fetal monitoring in pregnancies when there is:

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

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 # 61
This tracing demonstrates:



- A. Bradycardia
- B. Prolonged deceleration
- C. Category III tracing

Answer: B

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
A prolonged deceleration is defined by NICHD and NCC as:
* A deceleration lasting #2 minutes but <10 minutes
* Decrease in FHR of #15 bpm
* Can occur with or without uterine contractions
This tracing shows:
* A deep drop in FHR down to ~60-70 bpm
* Duration lasting several minutes

* Recovery back to baseline
* Moderate variability present afterward
Because variability remains present and the tracing does not show:
* Absent variability
* Recurrent late decelerations
* Recurrent variable decelerations with absent variability
* Bradycardia for #10 minutes
...it does not meet criteria for Category III.
It is also not bradycardia, because bradycardia requires:
* Baseline <110 bpm for 10 minutes or longer
Therefore the correct interpretation is a prolonged deceleration.
References:NCC C-EFM Candidate Guide; NICHD FHR Definitions; AWHONN FHMPP; Menihan; Simpson & Creehan.

NEW QUESTION # 62
Sustained fetal supraventricular tachycardia that goes untreated is most likely to result in:

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

Answer: B

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 # 63
Usually, the duration of an early deceleration in comparison with the contraction is:

- A. The same
- B. Longer
- C. Shorter

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
An early deceleration is defined by NICHD and NCC as a gradual decrease and return of the fetal heart rate associated with uterine contractions. NCC emphasizes that early decelerations are:
* Symmetrical
* Uniform in shape
* Mirror images of the contraction
This means:

* Onset of deceleration = onset of contraction
* Nadir of deceleration = peak of contraction
* Recovery = end of contraction
* Duration of the deceleration # duration of the contraction
Thus, the correct answer is C. The same.
References:NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; NICHD Definitions; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing.

NEW QUESTION # 64
Interventions undertaken to address fetal tachycardia are targeted at maximizing

- A. maternal circulation
- B. sympathetic autonomic tone
- C. uteroplacental perfusion

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Fetal tachycardia is typically caused by maternal fever, dehydration, hypoxia, medications, infection, or fetal stress. AWHONN and Simpson & Creehan emphasize that management focuses on improving oxygen delivery across the placenta, which is governed by uteroplacental perfusion.
Menihan's EFM text states that "interventions for fetal tachycardia must address oxygen transfer by optimizing uteroplacental blood flow," including hydration, reducing uterine activity, maternal repositioning, and treating maternal fever.
Increasing maternal circulation alone is insufficient unless it improves placental blood flow. Enhancing fetal sympathetic tone is not a clinical goal and would worsen tachycardia.
Creasy & Resnik highlight that fetal heart rate abnormalities resolve when uteroplacental perfusion is restored, confirming this as the primary target of intervention.
References:
AWHONN - Fetal Heart Monitoring Principles & PracticesSimpson & Creehan - Perinatal NursingMenihan - Electronic Fetal MonitoringCreasy & Resnik - Maternal-Fetal MedicineMiller's Pocket Guide

NEW QUESTION # 65
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