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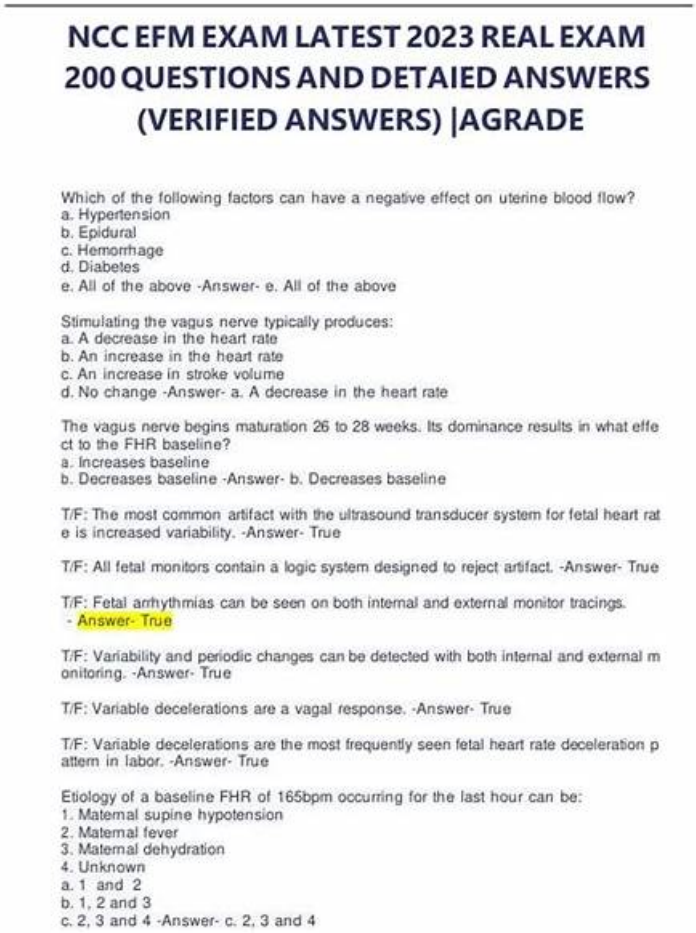

NCC EFM EXAM LATEST 2023 REAL EXAM 200 QUESTIONS AND DETAIED ANSWERS (VERIFIED ANSWERS) |AGRADE

Which of the following factors can have a negative effect on uterine blood flow?
a. Hypertension
b. Epidural
c. Hemorrhage
d. Diabetes
e. All of the above -Answer- e. All of the above

Stimulating the vagus nerve typically produces:
a. A decrease in the heart rate
b. An increase in the heart rate
c. An increase in stroke volume
d. No change -Answer- a. A decrease in the heart rate

The vagus nerve begins maturation 26 to 28 weeks. Its dominance results in what effe ct to the FHR baseline?
a. Increases baseline
b. Decreases baseline -Answer- b. Decreases baseline

T/F: The most common artifact with the ultrasound transducer system for fetal heart rat e is increased variability. -Answer- True

T/F: All fetal monitors contain a logic system designed to reject artifact. -Answer- True

T/F: Fetal arrhythmias can be seen on both internal and external monitor tracings. - Answer- True

T/F: Variability and periodic changes can be detected with both internal and external m onitoring. -Answer- True

T/F: Variable decelerations are a vagal response. -Answer- True

T/F: Variable decelerations are the most frequently seen fetal heart rate deceleration p attern in labor. -Answer- True

Etiology of a baseline FHR of 165bpm occurring for the last hour can be:
1. Maternal supine hypotension
2. Maternal fever
3. Maternal dehydration
4. Unknown
a. 1 and 2
b. 1, 2 and 3
c. 2, 3 and 4 -Answer- c. 2, 3 and 4

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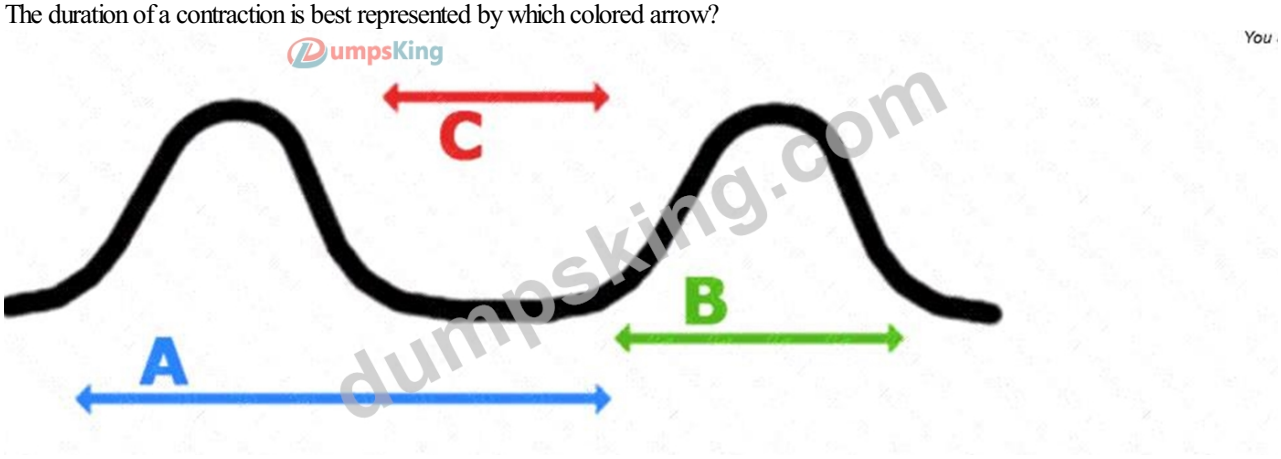
The NCC EFM certification exam has grown in popularity in today's modern NCC era. Success in the EFM exam gives aspirants the chance to upskill and remain competitive in the challanging job market. Those who successfully crack the Certified - Electronic Fetal Monitoring (EFM) test prove to their employers that they are skilled enough to get well-paying jobs and promotions. DumpsKing is aware that preparing with invalid NCC EFM Exam Questions wastes money and time.

NCC Certified - Electronic Fetal Monitoring Sample Questions (Q120-Q125):

NEW QUESTION # 120
The duration of a contraction is best represented by which colored arrow?

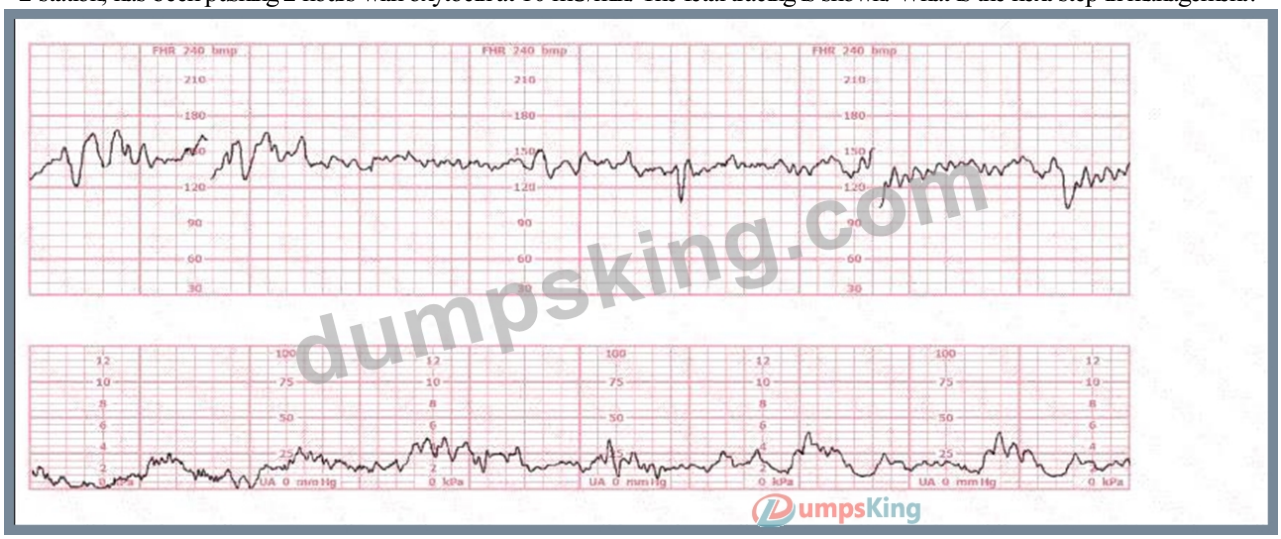


- A. Red (C)
- B. Green (B)
- C. Blue (A)

Answer: B

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 # 121
A nulliparous woman at term presents with leaking fluid. Rupture of membranes confirmed. After 6 hours she is completely dilated, +2 station, has been pushing 2 hours with oxytocin at 10 mU/min. The fetal tracing is shown. What is the next step in management?

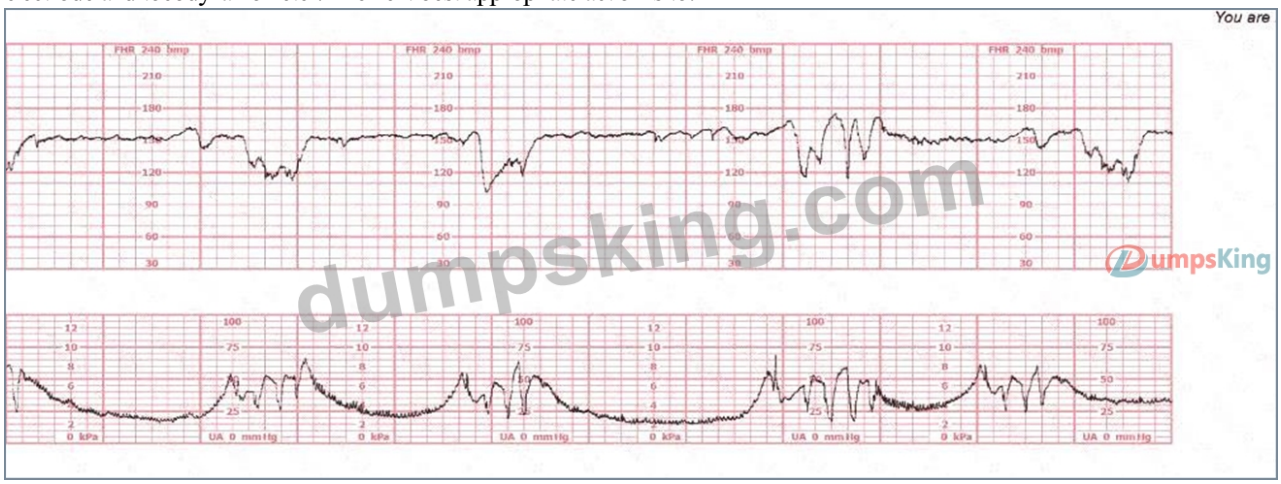


- A. Expedite birth
- B. Decrease oxytocin
- C. Continue pushing for another hour

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract Without Any URLs or Links:
According to the NCC C-EFM 2025 Exam Content Outline and recommended references such as AWHONN Fetal Heart Monitoring Principles, Simpson & Miller (Fetal Monitoring Text), and Menihan's EFM Guide, recurrent variable or late decelerations with minimal or moderate variability during the second stage of labor-particularly when the patient has been pushing for #2 hours-indicate progressive fetal intolerance of labor.
AWHONN states that when the fetal tracing displays recurrent variable decelerations with ongoing stress from long second stage, the recommended intervention is operative or expedited vaginal birth, provided the fetal station is at +2 or lower. AWHONN and Simpson emphasize that reducing oxytocin is insufficient when the tracing demonstrates ongoing significant decelerations during active pushing with adequate descent.
The NCC blueprint within Pattern Recognition & Intervention emphasizes:
* Identifying worsening recurrent decelerations
* Acting when fetal tolerance is decreasing
* Prioritizing timely intervention when the second stage exceeds standard limits with a non-reassuring tracing Because she is fully dilated, vertex at +2, and tracing shows recurrent decelerations during pushing, the evidence-based next step is expediting birth, typically via operative vaginal delivery.
References:AWHONN Fetal Heart Monitoring Principles & PracticesSimpson & Miller: Fetal MonitoringMenihan: Electronic Fetal MonitoringNCC C-EFM Exam Content Outline 2025

NEW QUESTION # 122
A woman at 39-weeks gestation is being induced. She has chronic hypertension controlled by methyldopa (Aldomet). Spontaneous rupture of membranes has occurred; she is 10 cm dilated and at +1 station. The fetal monitor tracing shown is obtained by spiral electrode and tocodynamometer. The next best appropriate action is to:



- A. Consider amnioinfusion
- B. Administer terbutaline
- C. Modify pushing

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The tracing shows recurrent variable decelerations deepening during contractions as the patient is fully dilated and at +1 station.
NCC's Pattern Recognition and Intervention framework states:
* During second stage (complete dilation), variable decelerations commonly occur from cord compression caused by head descent and maternal pushing efforts.
* The FIRST correction for pushing-associated recurrent variable decelerations is modifying the pushing technique:
* Side-lying pushing
* Pushing with every other contraction
* Open-glottis pushing
* Allowing passive descent
These measures relieve head compression and reduce the severity of variable decelerations.
Why the other answers are incorrect

A). Administer terbutaline
* Terbutaline is given for tachysystole with fetal intolerance.
* This tracing does not show tachysystole.
* The pattern is timing-related to pushing, not uterine overstimulation.
B). Consider amnioinfusion
* Amnioinfusion is used for recurrent variable decelerations before complete dilation, when membrane rupture + low fluid is suspected.
* At 10 cm and +1, the fetal head is deep in the pelvis, and the cause of variables is head compression, not cord compression due to oligohydramnios.
* Also, amnioinfusion is impractical and not beneficial at this stage.
Therefore, the correct answer is C. Modify pushing.
References:NCC C-EFM Candidate Guide; NCC Content Outline; AWHONN Principles & Practices; Miller' s Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 123
Fetal cardiac output is essentially dependent on the fetal:

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

Answer: C

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 # 124
The fetal heart rate baseline is

- A. documented in a 15 beats per minute range
- B. established between periodic and episodic changes
- C. normally between 110 and 170 beats per minute

Answer: B

Explanation:
Comprehensive and Detailed Explanation (From NCC C-EFM-Referenced Sources) The NCC C-EFM exam outline, along with AWHONN and Miller's Pocket Guide, define baseline fetal heart rate as the mean FHR rounded to increments of 5 bpm, measured over a 10-minute window, excluding:
* accelerations
* decelerations
* periods of marked variability
* any segments differing by >25 bpm
This aligns with ACOG, AWHONN, and Simpson's interpretation standards.

Option A is incorrect: the baseline is not documented as a 15-bpm range; it is documented as a single value (e.g., 140 bpm).
Option C is incorrect: the correct NCC/ACOG standardized normal baseline is 110-160 bpm, not 170.
Exact Extract Concepts Referenced:
- "Baseline is determined over a 10-minute period excluding periodic or episodic changes." (AWHONN FHR Principles)
- "Baseline is the mean FHR rounded to 5-bpm increments." (Miller's Pocket Guide)
- "Normal baseline is 110-160 bpm." (Simpson & Menihan; Creasy & Resnik)

NEW QUESTION # 125
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