Free PDF NCC EFM - Certified - Electronic Fetal Monitoring Official Study Guide

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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 - correct answer e. All of the above

How does the fetus compensate for decreased maternal circulating volume?
a. Increases cardiac output by increasing stroke volume.
b. Increases cardiac output by increasing it's heart rate.
c. Increases cardiac output by increasing fetal movement. - correct answer b. Increases cardiac output by increasing it's heart rate.

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 - correct answer a. A decrease in the heart rate

What initially causes a chemoreceptor response?
a. Epidurals
b. Supine maternal position
c. Increased CO2 levels
d. Decreased O2 levels
e. A & C
f. A & B
g. C & D - correct answer g. C & D

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

T/F: Oxygen exchange in the placenta takes place in the intervillous space. - correct answer True

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q63-Q68):

NEW QUESTION # 63
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 # 64
This fetal heart rate pattern is classified as Category III based on:

- A. Absent variability
- B. Type of deceleration
- C. Contraction pattern

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
This tracing shows recurrent late decelerations accompanied by absent variability.
Per NICHD/NCC, a tracing is Category III if ANY of the following are present:
* Absent variability AND recurrent late decelerations
* Absent variability AND recurrent variable decelerations
* Absent variability AND bradycardia
* Sinusoidal pattern
In this strip:
* Variability is absent
* Decelerations are recurrent and late
The determining feature for the classification is absent variability, which indicates significant risk for fetal acidemia.
The contraction pattern (option B) does not determine category.
The deceleration type alone (option C) does not determine Category III without absent variability.
Thus, the classification is Category III because of absent variability.
References:NCC C-EFM Candidate Guide; NICHD Three-Tier System; AWHONN Fetal Heart Monitoring Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring.

NEW QUESTION # 65
A key differentiating factor when determining if a deceleration is early or late is the

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

Answer: C

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 # 66
(Full question statement)
A dysrhythmia is noted. The pregnancy and labor course has been normal with no complications. The next step in management is to

- A. administer maternal oxygen
- B. start an IV fluid bolus
- C. continue to observe

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (NCC C-EFM sources: AWHONN, Miller's Pocket Guide, Menihan, Simpson, Creasy & Resnik, 2025 Candidate Guide) AWHONN and Menihan emphasize that most fetal dysrhythmias detected intrapartum are premature atrial contractions (PACs)-the most common benign rhythm variation. They typically appear as intermittent, irregular deflections on the fetal heart rate tracing without affecting variability or baseline.
Miller's Pocket Guide to Fetal Monitoring states that PACs are usually transient, self-limiting, and require only observation unless accompanied by tachyarrhythmia or hemodynamic compromise. When variability is preserved and no repetitive pattern or sustained tachycardia occurs, no intrauterine resuscitation measures are indicated.
Simpson and Creehan describe that oxygen administration and fluid boluses are not recommended for benign dysrhythmias, as they do not improve fetal conduction patterns and may contribute to unnecessary interventions.
The NCC 2025 Candidate Guide specifies that correct management requires distinguishing benign arrhythmias from pathologic tachyarrhythmias, which would require escalation. In the absence of fetal compromise or maternal pathology, the appropriate action is continued observation.
Therefore, the correct management is to continue to observe.

NEW QUESTION # 67
A patient presents at 38-weeks gestation with complaints of decreased fetal movement and ruptured membranes. The fetal heart rate is not able to be determined with an external ultrasound monitor. A spiral electrode is placed, and the tracing shows a rate of 90 bpm. What is the next most appropriate action?

- A. Intrauterine resuscitation measures
- B. Palpation of the maternal radial pulse
- C. Request for an urgent bedside ultrasound

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Whenever a fetal heart rate is unexpectedly low (such as 90 bpm), the FIRST step per NCC and AWHONN is to confirm that the signal is fetal, not maternal.
Even internal spiral electrodes can capture maternal heart rate, especially after:
* Rupture of membranes
* Maternal hypotension
* Maternal dehydration

* Maternal tachycardia or bradycardia
Thus, the first, most immediate action is:
Palpate the maternal radial pulse to determine whether the tracing is maternal or fetal.
If rates match # the monitor is falsely detecting the maternal pulse.
If rates differ # confirm true fetal bradycardia and begin intrauterine resuscitation.
Why the other options are incorrect:
* A. Intrauterine resuscitation - should NOT begin before confirming the tracing is fetal.
* C. Bedside ultrasound - appropriate after confirming that the tracing is not maternal, not before.
Correct answer: B. Palpation of the maternal radial pulse.
References:NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan; Miller's Pocket Guide; Simpson & Creehan.

NEW QUESTION # 68
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