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EFM practice test exam Questions with Answer 2023-2024

What FHR finding is top priority for immediate interventions?
a. heart block rate of 60 bpm
b.bradycardia
c.tachycardia with minimal variability rate of 170 with pushing - answers>>B. BRADYCARDIA

The change from moderate to minimal variability which is most concerning would be when:
a. association with tachysystole with or without pitocin
b. association after giving stadol and phenergan
c. association with active phase of pushing +3 station - answers>>a. association with tachysystole with or without pitocin

Explain the difference between "shoulders" and "overshoots" associated with variable decels (not approved NICHD approved terminology
a.shoulders are associated with moderate variability
b. over shoots are associated with moderate variability
c. shoulders are associated with minimal variability and overshoots are associated with absent variability - answers>>a.shoulders are associated with moderate variability

Define tachysystole with pitocin:
a. tachysystole is > or equal to 5 contractions in 10 minutes averaged over a 30-minute time frame but only with fetal intolerance
b. tachysystole is > or equal to 5 contractions in 10 minutes averaged over a 30-min time despite fetal intolerance of pattern, category 1 tracing
c. tachysystole is >5 contractions in 10 minutes averaged over a 30-min period of time - answers>>c. tachysystole is >5 contractions in 10 minutes averaged over a 30-min period of time

What category tracing is baseline rate of 120, absent variability and prolonged 5-minute decel to the 60s?
a. cat 1

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q55-Q60):

NEW QUESTION # 55
Based on the tracing shown, the first action should be to

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

Answer: A

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 # 56
The fetal heart rate tracing shown demonstrates:

- A. Category II tracing
- B. Accelerations
- C. Marked variability

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC C-EFM uses NICHD terminology to describe key FHR characteristics: baseline, variability, accelerations, and decelerations. In this strip, the following findings are present:
* Baseline:The baseline appears approximately 135-145 bpm, which is within the normal 110-160 bpm range described in NCC and AWHONN materials.
* Variability:Beat-to-beat fluctuation is within 6-25 bpm, which meets the definition of moderate variability. NCC and NICHD define moderate variability as amplitude range of 6-25 bpm; this is associated with adequate fetal oxygenation and a normal fetal acid-base status.
* Accelerations:The tracing shows distinct increases in FHR above the baseline by at least 15 bpm lasting 15 seconds or more but less than 2 minutes. NCC and NICHD define an acceleration in a term fetus precisely as "a visually apparent abrupt increase in FHR, with peak #15 bpm above baseline, lasting #15 seconds and <2 minutes." The pattern shown fits this definition clearly.
* Category determination:A tracing with normal baseline, moderate variability, and accelerations without decelerations is classified as Category I, not Category II. Category II is reserved for tracings that are not clearly Category I or III, such as minimal or marked variability, recurrent variables, or prolonged decelerations.
* Marked variability consideration:Marked variability is defined as amplitude >25 bpm. While the tracing is somewhat jagged, the fluctuation does not sustain >25 bpm amplitude over a 10-minute segment and instead remains in the moderate range, so it does not meet criteria for marked variability.
Given these observations, the most accurate description of the tracing from the options provided is that it demonstrates accelerations.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Three-Tier FHR Interpretation System; AWHONN Fetal Heart Monitoring Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 57

A pattern of recurrent variable decelerations would move from Category II to Category III if what fetal heart rate change occurs?

- A. Absent variability
- B. Tachysystole
- C. Late decelerations

Answer: A

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
Category III criteria include:
* Absent variability with recurrent variable decelerations
* Absent variability with recurrent lates
* Absent variability with bradycardia
* Sinusoidal pattern
Thus, recurrent variables become Category III when accompanied by absent variability, indicating fetal decompensation.
Why the other answers are wrong:
* B. Late decelerations # Category III only if combined with absent variability.
* C. Tachysystole # Contraction pattern, not a FHR characteristic.
Correct answer: Absent variability.
References:NCC C-EFM Candidate Guide; NICHD Definitions; AWHONN FHMPP.

NEW QUESTION # 58
When a difference in interpretation occurs over a non-emergent electronic fetal heart rate tracing, the first step toward resolution is to:

- A. Follow the chain of command
- B. Document the incident in the medical record
- C. Have the involved clinicians review the tracing together

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC's Professional Issues domain emphasizes communication, collaboration, and team-based interpretation of electronic fetal monitoring tracings.
For non-emergent differences in interpretation, the first step is:
* Discussion and joint review of the tracing by the involved clinicians.
Only if disagreement persists should the chain of command be used. Documentation occurs after consensus or escalation-not as the first step.
Thus, the appropriate first step is C. Have the involved clinicians review the tracing together.
References:NCC C-EFM Candidate Guide; AWHONN Standards for Professional Fetal Monitoring Practice; TeamSTEPPS principles.

NEW QUESTION # 59
The fetal heart rate tracing shown is consistent with

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

Answer: A

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 & PracticesMenihan - Electronic Fetal MonitoringSimpson & Creehan - Perinatal NursingCreasy & Resnik - Maternal-Fetal MedicineMiller's Pocket Guide to Fetal Monitoring

NEW QUESTION # 60
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