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NCC EFM test 1 with complete solutions

Variable decelerations are thought to be caused by:
A. Fetal head compression
B. Umbilical cord compression
c. Uteroplacental insufficiency - Answer- B. Umbilical cord compression

An appropriate treatment for recurrent variable decelerations with moderate variability during second stage pushing is:
A. Amnioinfusion
B. Modification of pushing efforts
C. Oxygen at 10 liters per nonrebreather face mask. - Answer- B. Modification of pushing efforts

The Primary purpose of the use of electronic fetal monitoring is to:
A. Determine if the fetus is well oxygenated
B. Document fetal status throughout labor
C. Identify the fetus at risk - Answer- C. Identify the fetus at risk

An EFM tracing with fetal heart rate of 170 beats per minute and moderate variability would be classified as:
A. Abnormal (category III)
B. Indeterminate (category II)
C. Normal (category I) - Answer- B. Indeterminate (category II)

When variability is undetectable, it is identified as:
A. Absent
B. Decreased
C. Indeterminate - Answer- A. Absent

When periodic fetal heart rate patterns occur, they:
A. Are associated with uterine contractions
B. Are classified as indeterminate
C. Require a fetal spiral electrode for accurate determination. - Answer- A. Are associated with uterine contractions

Interpretation and classification of fetal heart rate patterns are determined:
A. Are associated with uterine contractions
B. Based on EFM findings observed for a 60 minute period of time.

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q23-Q28):

NEW QUESTION # 23
When documenting the occurrence of late decelerations in the medical record, what should be charted?

- A. Notation that the tracing was normal or abnormal
- B. Components of the tracing
- C. Tracing category

Answer: B

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
According to NCC, AWHONN, and evidence-based documentation standards, clinicians must document:
* Baseline
* Variability
* Accelerations
* Decelerations (type, depth, duration, timing)
* Uterine activity
This fulfills the NICHD 3-tier system and legal documentation expectations.
Why the incorrect answers are wrong:
* B. "Normal/abnormal" # vague, not an acceptable documentation standard.
* C. Category alone # insufficient; categories must be supported by the components.
References:NCC C-EFM Candidate Guide; AWHONN Documentation Standards; Menihan.

NEW QUESTION # 24
Uterine contraction intensity is manually measured by degree of uterine:

- A. Indentation
- B. Pain
- C. Muscle strength

Answer: A

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Equipment Concepts:
When using external tocodynamometry, uterine contraction intensity cannot be measured in mmHg. It is assessed manually, using palpation. NCC and AWHONN teach:
* Contraction intensity is estimated by palpating the fundus during a contraction.
* The degree of firmness versus indentation determines intensity:
* Mild # uterus easily indented
* Moderate # firm, difficult to indent
* Strong # rigid, cannot be indented
Why the incorrect answers are wrong:
* B. Muscle strength - Not measurable by external or manual exam.
* C. Pain - Not a reliable indicator; pain perception varies widely and does not correlate with uterine intensity.
Thus, the correct manual measurement is done through uterine indentation, making A correct.
References:NCC C-EFM Candidate Guide; AWHONN Principles & Practices; Menihan EFM; Miller's Pocket Guide; Simpson & Creehan.

NEW QUESTION # 25
Fetal cardiac output is essentially dependent on the fetal:

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

Answer: B

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 # 26
A patient at 41 weeks gestation is being induced. She has progressed slowly and is now at 6 cm, 90% effaced, -1 station. She has the fetal heart tracing shown despite repositioning. The next step in the management of this patient should be to:

- A. Perform an amnioinfusion
- B. Decrease the oxytocin
- C. Apply a spiral electrode

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The tracing clearly shows recurrent deep variable decelerations, characterized by:
* Abrupt onset (<30 sec)
* Sharp V-shape
* Rapid descent and ascent
* Depth exceeding 60-70 bpm drops
* Occurring with most contractions
This pattern is highly consistent with cord compression, which is the physiologic basis of variable decelerations. According to NCC, NICHD, AWHONN, Miller, and Menihan, recurrent (#50% of contractions) deep variables with slow return to baseline indicate fetal compromise and require targeted intervention.
The patient has already been repositioned, so first-line management has failed. NCC emphasizes that the next recommended intervention for recurrent variable decelerations, particularly when maternal repositioning is ineffective, is amnioinfusion. This intervention relieves cord compression by restoring fluid around the umbilical cord.
Why the other choices are incorrect:
A). Apply a spiral electrode - NOT appropriate
* Spiral electrodes improve signal quality but do not treat cord compression.
* The tracing is already clearly interpretable, and the issue is physiologic, not technical.
B). Decrease the oxytocin - Not the best next step
* Decreasing oxytocin is appropriate when tachysystole is contributing to fetal intolerance.
* This strip shows normal contraction frequency (about every 2-3 minutes) and no tachysystole.
* Thus, reducing oxytocin alone will not relieve cord compression.
C). Perform an amnioinfusion - CORRECT
NCC-approved references repeatedly state:
* For recurrent variable decelerations that persist after maternal repositioning, amnioinfusion is recommended to reduce the frequency and depth of decelerations.
* It can improve fetal oxygenation, decrease cord compression, and reduce the need for operative delivery.
* It is the intervention most directly targeted to the pathophysiology of this pattern.
Therefore, C. Perform an amnioinfusion is the correct next management step.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD 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 # 27
A 30-minute tracing with moderate variability, accelerations, and one variable deceleration would be classified as:

- A. Category II
- B. Category I
- C. Category III

Answer: A

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
NICHD/NCC criteria:
Category I must have ALL of the following:
* Baseline 110-160 bpm
* Moderate variability
* No late or variable decelerations
* Early decelerations may be present or absent
* Accelerations may be present or absent
Because this tracing has one variable deceleration, it fails Category I criterion ("no late or variable decelerations").
Category III requires:
* Absent variability with recurrent late decels, recurrent variables, or bradycardia, or
* Sinusoidal pattern
Those findings are not present.
Therefore, any tracing that:
* Has moderate variability and accelerations,
* But includes a variable deceleration, and
* Does not meet Category III criteria
...falls into the Category II (indeterminate) group.
Correct classification: B. Category II.
References:NCC C-EFM Candidate Guide; NICHD Three-Tier FHR Interpretation System; AWHONN FHMPP; Menihan; Simpson & Creehan.

NEW QUESTION # 28
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