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NCC EFM Practice Questions and Answers Latest Update 2024/2025 (GRADED)

What are some important factors (risks) to consider when evaluating a fetal heart rate strip? - --"PNLs" (abnormal?)
--weight gain/loss
--Maternal age
--"Gestational age"
--"MATERNAL vital signs"
--"Membrane status"
--"Cervical exam"

What are the easiest ways for assessment of maternal oxygenation status? - *Pulse Ox* (& other vital signs, RR)
Blood gas (if indicated, asthma exacerbation)
Lung sounds (pneumonia, pulmonary edema?)
What effect can *HTN/Preeclampsia* have on the Placenta? -
VASOCONSTRICTION
which adversely effects placental perfusion and can lead to:
--"IUGR"
--"infarcts" (decreases functional area of the placenta & functional capacity)
Placental infarcts - - Necrosis of placental villi
- Anechoic or Hypochoic areas in placenta
Placental infarcts will do what to the placental function? - *DECREASE functional area* of placenta
DECREASE functional capacity
What effect can *Diabetes* have on Placental perfusion? - Secondary to *Maternal Vasculopathy* & *HYPERglycemia* this can lead to:
reduced utero-placental perfusion = *IUGR*
What can change for fetal energy demands when you have a *DIABETIC mother* uncontrolled and there is *Fetal HYPERglycemia & HYPERinsulinemia*? - Fetal hyperglycemia & hyperinsulinemia can cause:
increased fetal O2 consumption which may induce *fetal hypoxemia & acidosis* if the O2 needs of the fetus are not met by the placenta.
What are some common conditions which could lead to a *POOR maternal Oxygenation status*? - Respiratory DEPRESSION (*Meds or Seizure*)
Pulmonary EMBOLISM
Pneumonia
Asthma
Atelectasis

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q10-Q15):

NEW QUESTION # 10

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:

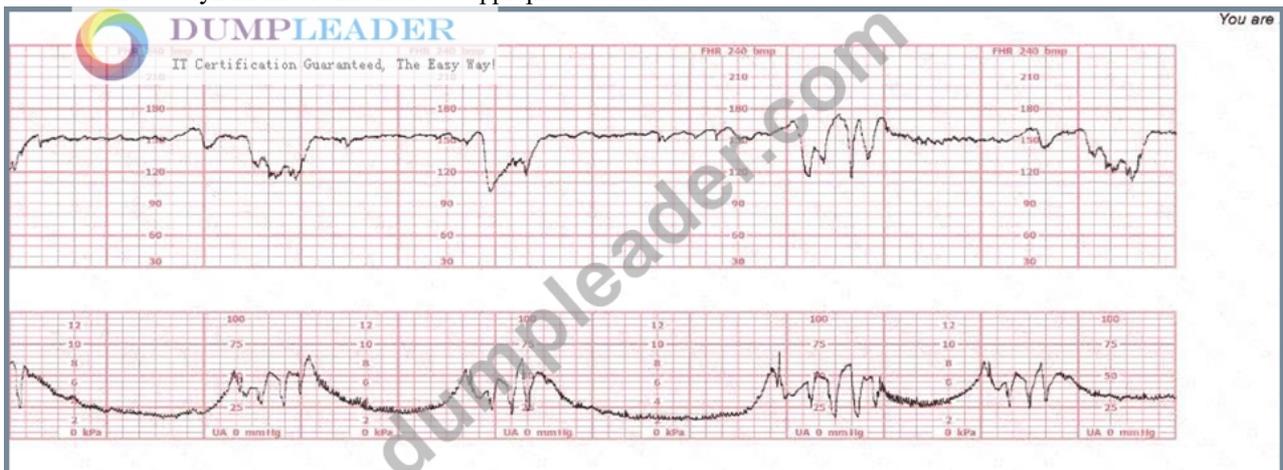
* Early decelerations: "mirror the contraction; onset, nadir, and recovery occur simultaneously with the contraction."

* 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 # 11

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

Answer: A

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 # 12

A fetal heart rate pattern characteristic of fetal neurological injury and impending intrapartum fetal demise is:

- A. Recurrent late decelerations
- B. Marked variability
- C. Wandering baseline

Answer: C

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

A wandering baseline is:

- * A slow, fluctuating baseline
- * Low amplitude
- * No variability
- * No accelerations
- * Indicative of severe fetal neurologic injury and terminal fetal status NCC and AWHONN describe wandering baseline as a preterminal pattern.

Why the other answers are wrong:

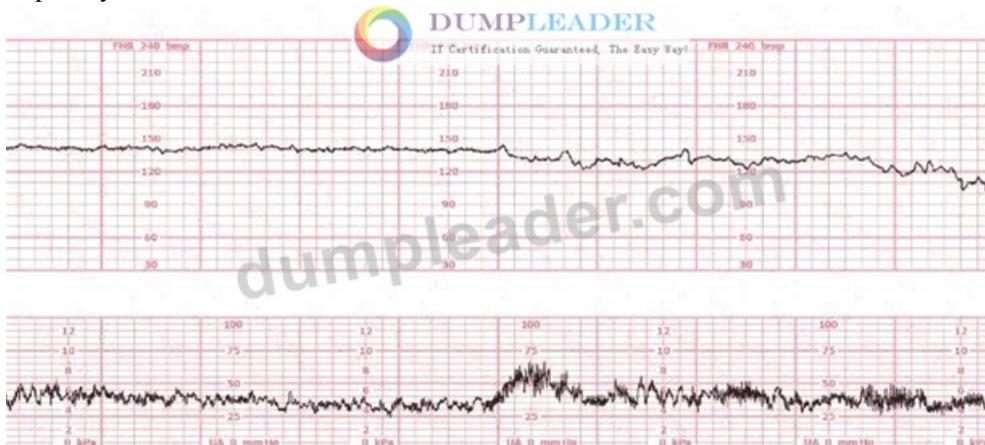
- * A. Marked variability # often transient and not associated with demise.
- * B. Recurrent lates # concerning but not a neurological-injury pattern unless variability absent.

Correct answer: C. Wandering baseline.

References: NCC Pattern Recognition; AWHONN FHMPP; Menihan; Simpson & Creehan.

NEW QUESTION # 13

This external tracing is from a 19-year-old (G1P0) at 39-weeks gestation. She is 6 cm dilated, 100% effaced, and -2 station. The fetus is in an occiput posterior position. She rates her pain as 8. She reports being lightheaded. She is most likely at risk for respiratory:



- A. Alkalosis
- B. Acidosis

- C. Depression

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Physiologic References:

This strip shows:

- * Baseline around 150 bpm
- * Moderate variability
- * No decelerations
- * Consistent, strong contractions
- * A maternal report of severe pain (8/10) and feeling lightheaded

In labor, severe pain + anxiety + hyperventilation commonly cause maternal respiratory alkalosis.

NCC and AWHONN physiology guidance explain:

- * Hyperventilation ## PaCO₂ ## respiratory alkalosis

* Symptoms include:

- * Lightheadedness
- * Tingling
- * Dizziness
- * Sometimes palpitations

* This frequently occurs during painful contractions, especially with occiput posterior labor, which is notoriously more painful due to back pressure.

Why other answers are incorrect:

- * A. Respiratory acidosis occurs with hypoventilation-not present here.
- * C. Respiratory depression occurs with opioids, magnesium sulfate, or anesthesia-not part of this scenario.

Therefore, the correct answer is B. Alkalosis.

References: NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan EFM; Miller's Pocket Guide; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 14

A 30-year-old woman (G2P0) is experiencing preterm labor at 26-weeks gestation. She is receiving magnesium sulfate for neuroprotection. Her external fetal monitoring tracing over the past 30 minutes is shown. The next step would be to:



- A. Administer acetaminophen
- **B. Evaluate for chorioamnionitis**
- C. Discontinue magnesium sulfate

Answer: B

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

This tracing shows:

- * Baseline ~170-175 bpm # fetal tachycardia
- * Minimal variability
- * No contractions of significance

* Maternal treatment with magnesium sulfate, which typically decreases baseline and variability-not increase it NCC and AWHONN physiology guidelines emphasize that fetal tachycardia is most commonly associated with maternal infection, including chorioamnionitis, especially in preterm labor.

Magnesium sulfate does not cause tachycardia; it generally causes:

* # baseline

* # variability

Thus, fetal tachycardia + minimal variability in a preterm patient strongly suggests maternal infection, requiring evaluation for chorioamnionitis.

Why the wrong answers are incorrect:

* A. Acetaminophen # used after confirming fever, not before evaluating the cause.

* B. Discontinuing magnesium # magnesium sulfate does not cause tachycardia; discontinuing it removes fetal neuroprotection.

References:NCC C-EFM Candidate Guide; AWHONN FHMPP; Simpson & Creehan; Menihan EFM; Creasy & Resnik.

NEW QUESTION # 15

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