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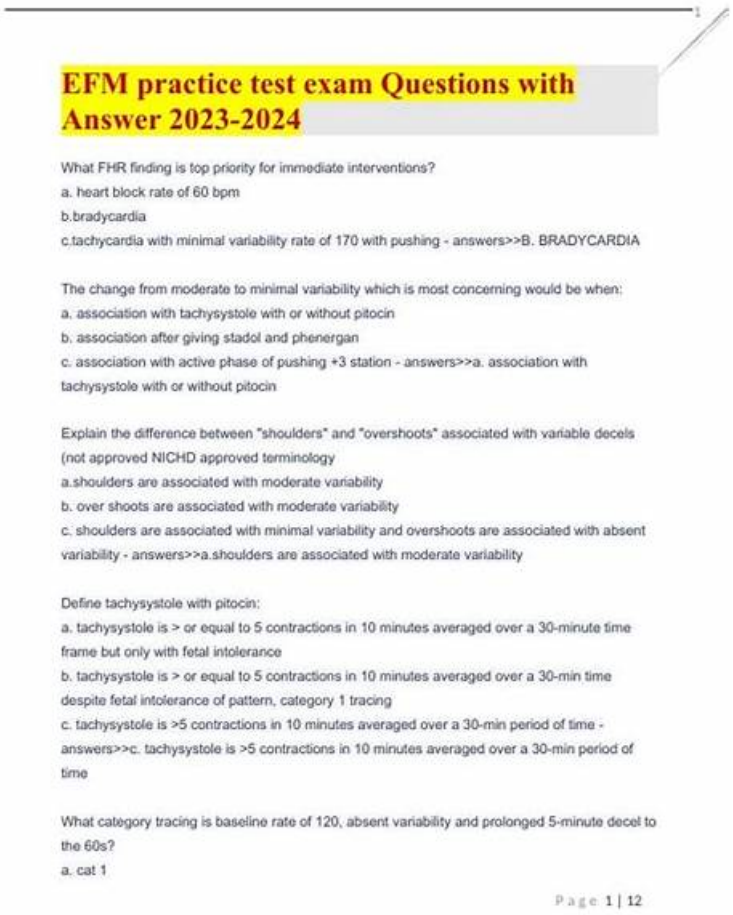

EFM practice test exam Questions with Answer 2023-2024

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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to choose the excellent workers for their company by the EFM Certification that the candidates have gained. More and more workers have to spend a lot of time on meeting the challenge of gaining the EFM certification by sitting for an exam.

NCC Certified - Electronic Fetal Monitoring Sample Questions (Q97-Q102):

NEW QUESTION # 97
In documenting auscultation of the fetal heart rate, it is important to record findings in relationship to:

- A. Fetal position
- B. Stage of labor
- C. Uterine activity

Answer: C

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
NCC and AWHONN auscultation standards emphasize the need to document FHR findings relative to uterine contractions, including:
* The FHR between contractions (baseline)
* FHR during contractions
* Presence/absence of decelerations
* Recovery after a contraction
Uterine activity determines whether findings are:
* Baseline
* Accelerations
* Early/late/variable decelerations
Why the other options are incorrect:
* A. Fetal position - relevant for Doppler placement, not auscultation documentation.
* B. Stage of labor - affects monitoring frequency but does not change how findings are documented.
Correct answer: C. Uterine activity.
References:NCC C-EFM Candidate Guide; AWHONN Standards for FHR Auscultation; Simpson & Creehan.

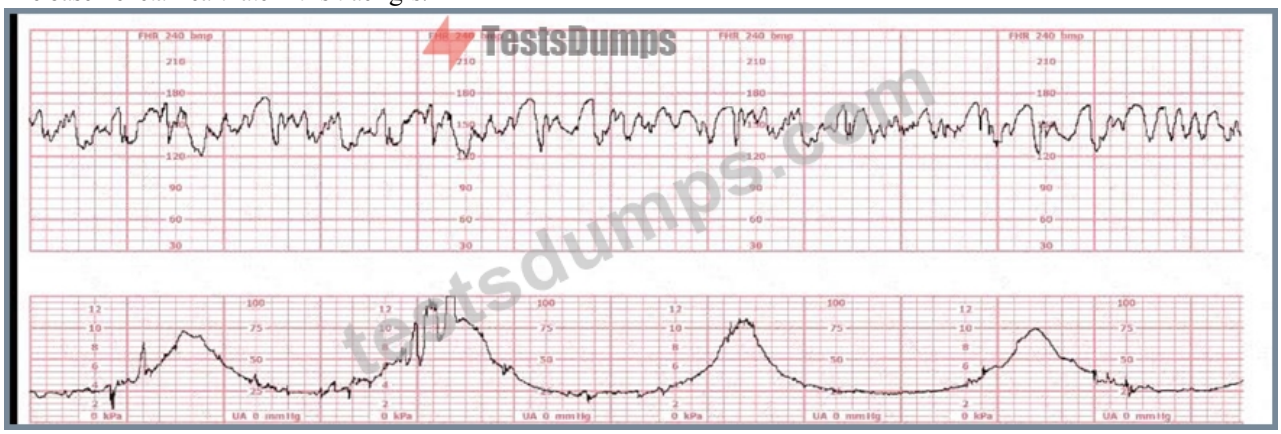
NEW QUESTION # 98
Fetal supraventricular tachycardia will often appear on the monitor as

- A. the same rate as the maternal pulse
- B. half the actual rate
- C. artifact

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources NCC-recommended fetal assessment texts emphasize that external Doppler ultrasound may undercount very rapid fetal arrhythmias such as fetal supraventricular tachycardia (SVT). Because Doppler detects mechanical motion rather than electrical activity, the device may record only every other cardiac contraction
, a phenomenon known as "half-counting."
Menihan's Electronic Fetal Monitoring explains that with SVT-often exceeding 200 to 260 bpm-the monitor "may display a fetal heart rate at approximately half the true atrial rate." AWHONN teaching materials affirm that rapid, regular tachyarrhythmias may appear deceptively slower on the external monitor due to Doppler under-sampling. Simpson & Creehan note that half-counting is a recognized technical limitation and may cause clinicians to miss true tachyarrhythmias if internal monitoring is not applied.
In contrast, artifact displays irregular, inconsistent, and non-physiologic deflections. Matching the maternal pulse suggests maternal heart rate misinterpretation, not SVT.
Miller's Pocket Guide also highlights that half-counting is "commonly seen in fetal SVT when using external Doppler due to failure to detect each rapid contraction." Therefore, fetal SVT most commonly appears as half the actual rate on an external fetal monitor.
References:
AWHONN - Fetal Heart Monitoring Principles & PracticesMenihan - Electronic Fetal MonitoringSimpson & Creehan - Perinatal NursingCreasy & Resnik - Maternal-Fetal MedicineMiller's Pocket Guide

NEW QUESTION # 99
The baseline fetal heart rate in this tracing is:



- A. Indeterminate
- B. 155 beats per minute
- C. Tachycardia

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
On the tracing:
* FHR consistently ranges 170-185 bpm.
* Variability remains present, confirming adequate signal.
* This pattern persists for the required minimum 10-minute baseline window.
NICHD/NCC define fetal tachycardia as:
* Baseline > 160 bpm for at least 10 minutes
Because the FHR is well above 160 for the whole reviewable period, the baseline is tachycardic.
Why the other answers are incorrect:
* A. 155 bpm - Too low; FHR visually averages well above this.
* B. Indeterminate - Not applicable; variability is clear and the tracing meets the #10-minute rule.
Correct answer: C. Tachycardia
References:NICHD Definitions; NCC C-EFM Candidate Guide; AWHONN; Miller; Menihan.

NEW QUESTION # 100
When a difference in interpretation occurs over a non-emergent electronic fetal heart rate tracing, the first step toward resolution is to:

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

Answer: B

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 # 101
Maternal fever can cause fetal tachycardia because the increased maternal temperature:

- A. Decreases tissue perfusion
- B. Inhibits catecholamine release
- C. Increases fetal metabolism

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Maternal hyperthermia-most commonly from infection-causes a rise in fetal temperature, which increases fetal metabolic rate. The fetus responds by increasing heart rate to meet the increased oxygen demand.
Effects include:
* Increased fetal oxygen consumption
* Enhanced fetal cardiac output
* Resultant tachycardia, often 160-180 bpm
This mechanism is repeatedly outlined in NCC's physiology domain, AWHONN, Menihan, Simpson, and Creasy & Resnik.
Option A is incorrect because maternal fever does not reduce perfusion.
Option C is incorrect because catecholamines are often elevated, not inhibited.
Thus, the mechanism is increased fetal metabolism.
References:NCC C-EFM Candidate Guide; NCC Physiology Domain; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy
& Resnik Maternal-Fetal Medicine.

NEW QUESTION # 102
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