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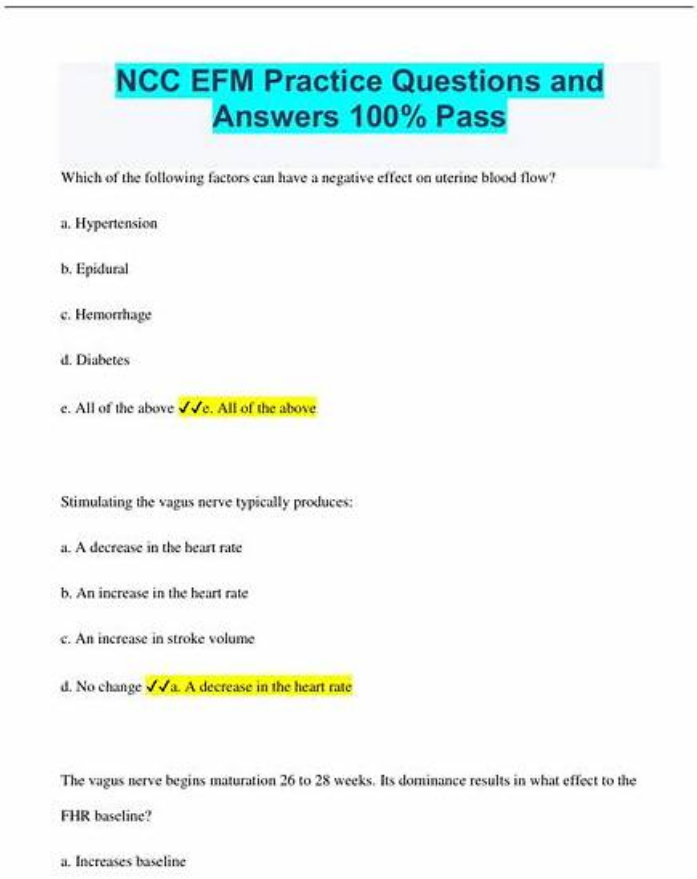

NCC EFM Practice Questions and Answers 100% Pass

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 ✓✓e. All of the above

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 ✓✓a. A decrease in the heart rate

The vagus nerve begins maturation 26 to 28 weeks. Its dominance results in what effect to the FHR baseline?

a. Increases baseline

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

NEW QUESTION # 23
A woman (G1P0) arrives in triage with a pain score of 4/10 at 39-weeks gestation. The fetal heart rate tracing shown is obtained. The best intervention is to:

- A. Discharge to home
- B. Admit for induction
- C. Adjust tocotransducer and continue to monitor

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
This tracing demonstrates a normal, reassuring fetal heart pattern that is technically categorized as Category I, indicating normal fetal acid-base status. Before any decision regarding discharge or induction, NCC emphasizes correct assessment of the tracing quality, fetal status, and uterine activity.
Key Tracing Characteristics
* Baseline:Approximately 135-145 bpm, well within the normal range of 110-160 bpm.
* Variability:The strip shows moderate variability (6-25 bpm), the strongest indicator of adequate fetal oxygenation per NCC, AWHONN, and NICHD.
* Accelerations:Several accelerations are present-another reassuring feature of normal fetal well-being.
* Decelerations:No variable, late, or prolonged decelerations are present.
* Uterine Activity:The lower channel shows poor recording quality and inconsistent signal- suggesting the toco is not capturing contractions well, not that the patient is contracting excessively or not at all.
Correct interpretation per NCC:
NCC emphasizes distinguishing between physiologic assessment and technical artifact.
The fetal tracing is completely reassuring.
The only abnormality is the poor uterine activity signal, a common triage occurrence due to:
* Toco placement
* Maternal body habitus
* Positioning
* Low contraction intensity in early labor
Thus, the correct next step is to optimize equipment (reposition the toco, adjust belt, palpate contractions) and continue to monitor.
Why the other options are incorrect:
B). Admit for induction - NOT indicated
* There is no evidence of fetal compromise.
* No indication for induction is present (pain score 4/10, reassuring FHR, term pregnancy).
* NCC emphasizes avoiding unnecessary interventions.
C). Discharge to home - NOT yet appropriate
* You cannot safely discharge a patient with a poorly monitored contraction pattern.
* Adequate assessment requires confirming uterine activity-after fixing the toco.
Therefore, the appropriate action is:
A). Adjust tocotransducer and continue to monitor.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; AWHONN Fetal Heart Monitoring Principles & Practices; NICHD Definitions; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 24
The fetal heart rate tracing shown is consistent with

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

Answer: B

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 # 25
A woman is admitted to labor and delivery with vaginal bleeding. This tracing is obtained. This is most consistent with:

- A. An indeterminate pattern
- B. Normal baseline
- C. Dysrhythmia

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The tracing shows:
* Baseline approx. 120 bpm
* Minimal variability (amplitude <5 bpm) across the entire strip
* No accelerations
* No decelerations
* Contractions present but not excessive
NCC defines:
* Category I requires moderate variability # not present.
* Category III requires absent variability with recurrent decels, bradycardia, or sinusoidal pattern # not present.
* Thus this falls into Category II: "indeterminate."
Minimal variability for this length of time cannot be considered a normal baseline, especially in the setting of vaginal bleeding, which raises concern for:
* Abruption
* Maternal anemia
* Hypovolemia
* Decreased uteroplacental perfusion
There is no evidence of dysrhythmia (no irregular R-R intervals, no chaotic spikes, no sawtooth pattern).
Therefore, the correct interpretation is A. An indeterminate pattern (Category II).
References:NCC C-EFM Candidate Guide; NICHD Definitions; AWHONN Principles & Practices; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 26
The tracing shown is a:

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

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The tracing demonstrates:
* Baseline: approx. 140 bpm
* Variability: minimal-to-moderate (fluctuating but not consistently moderate)
* Decelerations: shallow variable decelerations
* Accelerations: not consistently present
According to NICHD/NCC definitions:
Category I requires ALL of the following:
* Baseline 110-160
* Moderate variability
* No late or variable decelerations
* Early decels and accelerations may be present
This tracing does not have consistently moderate variability and does have variable decelerations, so it is not Category I.
Category III requires ANY of the following:
* Absent variability with recurrent late decels
* Absent variability with recurrent variable decels
* Absent variability with bradycardia
* Sinusoidal pattern
This tracing does not show absent variability, bradycardia, or recurrent significant lates.
Category II includes:
* Minimal variability
* Absence of accelerations
* Variable decelerations
* Tracings not clearly Category I or III
This strip fits Category II exactly due to minimal variability + intermittent variable decelerations.
Thus, the correct classification is Category II.
References:NCC C-EFM Candidate Guide; NICHD Three-Tier Interpretation System; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan; Miller; Simpson & Creehan.

NEW QUESTION # 27
Maternal conditions of autoimmunity can result in fetal heart block due to antibodies that target:

- A. Fetal red blood cells
- B. The fetal atrioventricular node
- C. Maternal white blood cells

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC physiology content specifically includes maternal autoimmune influences on fetal cardiac conduction.
Conditions such as maternal lupus (SLE) or Sjogren's syndrome may produce anti-Ro/SSA and anti-La /SSB antibodies. These antibodies cross the placenta and damage fetal conduction tissue.
The primary site of injury is the fetal atrioventricular (AV) node, leading to:
* First-, second-, or complete third-degree heart block
* A slow, regular ventricular rate typically 50-70 bpm
* Loss of beat-to-beat variability because ventricular myocardium does not display normal autonomic modulation This mechanism is extensively described in AWHONN, NCC physiology materials, and maternal-fetal physiology texts.
Option A: Antibodies do not target fetal RBCs; that describes hemolytic disease of the newborn.
Option B: Targeting maternal WBCs is not fetal-specific.
The correct affected structure is the fetal AV node.
Therefore, the correct answer is C. The fetal atrioventricular node.
References:NCC C-EFM Candidate Guide (2025); NCC Physiology Content Outline; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 28

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