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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 (Q28-Q33):

NEW QUESTION # 28
The decelerations seen in the fetal monitoring tracing shown are best described as:

- A. Early
- B. Late
- C. Variable

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Accurate classification of decelerations requires evaluating their shape, onset, nadir, recovery, relationship to contractions, and variability characteristics. NCC uses the NICHD standardized definitions, reinforced across AWHONN, Miller's Pocket Guide, Menihan, Simpson, and Creasy & Resnik.
Key features in this tracing:
* Abrupt onsetThe FHR drops rapidly from baseline to nadir in less than 30 seconds-this is the defining hallmark of a variable deceleration per NICHD.
* Sharp V-shape and deep amplitudeThe tracing shows steep descents and ascents, characteristic of cord compression-type variable decelerations.
* Inconsistent timing with contractionsThe decelerations do not begin at the start of contractions (as early decelerations would) and do not consistently begin after the peak of contractions (as late decelerations would). Variable decelerations can occur before, during, or after a contraction-exactly what is demonstrated here.
* Rapid return to baselineAnother core feature of variable decelerations in NICHD/NCC definitions.
* No uniform contraction relationshipEarly decelerations are symmetrical and mirror contractions.
Late decelerations begin after the peak of the contraction. This strip does not match either pattern.
Differentiation per NCC-aligned definitions:
* Early Decelerations:Gradual onset (>30 sec), nadir mirrors contraction peak, shallow, uniform.Not present.
* Late Decelerations:Gradual descent, nadir after contraction peak, smooth shape.Not present.
* Variable Decelerations:Abrupt onset (<30 sec), variable timing, sharp V-shape, rapid recovery, often with shoulders.Exactly matches the tracing.
Therefore, according to NICHD/NCC criteria, the decelerations shown are variable decelerations.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Standardized Definitions; 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 # 29
A 45-year-old woman at 36-weeks gestation presents for a nonstress test. Vital signs are:
* Maternal pulse rate: 86 beats per minute
* Blood pressure: 118/76 mm Hg
* Temperature: 36.7°C (98.1°F)
The next course of action would include:

- A. Induce labor
- B. Discharge home
- C. Perform a Kleihauer-Betke test

Answer: B

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
The NST strip shows:
* Baseline FHR about 140 bpm
* Moderate variability
* Two or more accelerations meeting 15×15 criteria
* No decelerations
* Normal, infrequent contractions
Per NCC and AWHONN, a reactive NST is defined as:
* #2 accelerations of 15 bpm × 15 seconds in a 20-minute period

* With baseline 110-160 and moderate variability
* No recurrent decelerations
A reactive NST at 36 weeks in a hemodynamically stable mother with normal vitals is reassuring, and the appropriate disposition is routine follow-up and discharge.
Why the other options are incorrect:
* B. Induce labor - Not indicated solely on maternal age or a reactive NST.
* C. Kleihauer-Betke test - Used to quantify fetomaternal hemorrhage after trauma or sensitization risk; there is no such history here.
Therefore, the correct action is A. Discharge home.
References:NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 30
(Full question statement)
The fetal heart rate tracing shown is obtained upon the woman's admission to labor and delivery. This tracing is most consistent with what maternal condition?

- A. Systemic lupus erythematosus
- B. Eisenmenger's syndrome
- C. Sickle cell anemia

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (NCC C-EFM sources: AWHONN, Miller's Pocket Guide, Menihan, Simpson, Creasy & Resnik, 2025 Candidate Guide) The tracing displays baseline fetal bradycardia, with a rate near 100 bpm, minimal variability, and preserved periodic response. According to AWHONN's Fetal Heart Monitoring Principles & Practices and Menihan's Electronic Fetal Monitoring, maternal conditions that reduce oxygen-carrying capacity- including maternal anemia-can lead to lower fetal oxygen delivery, prompting a fetal compensatory bradycardic baseline.
Creasy & Resnik's Maternal-Fetal Medicine notes that sickle cell anemia decreases maternal hemoglobin function even when maternal vital signs appear stable, reducing uteroplacental oxygen transport. Fetuses of mothers with sickling disorders may demonstrate lower resting fetal heart rates due to chronic mild hypoxemia.
Conversely, Eisenmenger's syndrome is associated with severe maternal cyanosis and high fetal mortality, often producing late decelerations and growth restriction rather than mild bradycardia. Systemic lupus erythematosus (SLE) is commonly associated with heart block (especially with anti-Ro/SSA antibodies), which is not displayed here, as true heart block presents with a fixed atrial-ventricular dissociation and FHR
< 60 bpm.
Thus, based on fetal physiology and maternal disease correlations taught in NCC-recommended sources, the tracing is most consistent with maternal sickle cell anemia.

NEW QUESTION # 31
A woman at 34-weeks gestation is in active labor after spontaneous rupture of membranes.
Accelerations should be documented as

- A. present 15×15
- B. present 10×10
- C. absent

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (No URLs)
For fetuses before 32-34 weeks, the National Certification Corporation (NCC) follows the physiologic standards established by AWHONN, Simpson & Creehan, Menihan, and Creasy & Resnik, which emphasize that preterm fetuses have less mature autonomic nervous system development, resulting in smaller and shorter accelerations.
According to the NCC C-EFM Exam Content Outline (Pattern Recognition & Intervention) and the AWHONN Fetal Heart Monitoring Principles (2022-2024):
* Preterm fetuses (<32 weeks) normally demonstrate 10 bpm × 10 sec accelerations.
* By approximately 32-34 weeks, accelerations may begin transitioning toward 15×15, but the accepted standard for

documentation at 34 weeks remains 10×10, unless clearly meeting 15×15 criteria.
* NCC emphasizes using gestational-age-appropriate criteria for documenting accelerations, because autonomic reactivity increases gradually and is not fully comparable to term until after
32-34 weeks.
Menihan's Electronic Fetal Monitoring also states that preterm fetuses "should be evaluated with the
10×10 rule until it is clear that the fetus is demonstrating mature 15×15 acceleratory capacity." Simpson & Creehan reinforce this point, noting that accelerations in late preterm gestations "may not consistently reach 15 bpm for 15 seconds, and thus 10×10 remains the appropriate designation." Since the patient is 34 weeks, the fetus is late-preterm and may not reliably meet the full 15×15 criteria; therefore, the correct documentation standard remains 10×10.
Thus, accelerations should be charted as:
"Present 10×10."
References
* NCC C-EFM Candidate Guide 2025 - Content Domain: Pattern Recognition and Intervention
* AWHONN Fetal Heart Monitoring Principles & Practices, 2022-2024
* Menihan: Electronic Fetal Monitoring: Concepts and Applications
* Simpson & Creehan: Perinatal Nursing
* Miller: Fetal Monitoring Pocket Guide
* Creasy & Resnik: Maternal-Fetal Medicine

NEW QUESTION # 32
The tracing shown is a:

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

Answer: C

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 # 33
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