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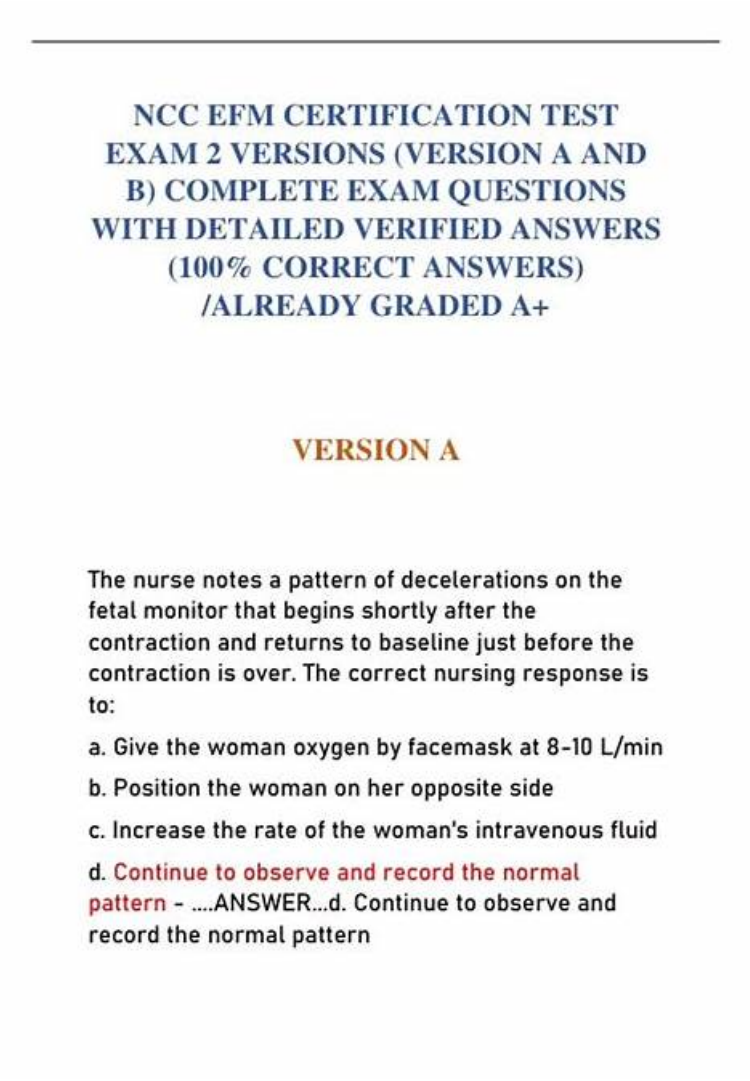
NCC EFM CERTIFICATION TEST
EXAM 2 VERSIONS (VERSION A AND
B) COMPLETE EXAM QUESTIONS
WITH DETAILED VERIFIED ANSWERS
(100% CORRECT ANSWERS)
/ALREADY GRADED A+

VERSION A

The nurse notes a pattern of decelerations on the fetal monitor that begins shortly after the contraction and returns to baseline just before the contraction is over. The correct nursing response is to:

a. Give the woman oxygen by facemask at 8-10 L/min

b. Position the woman on her opposite side

c. Increase the rate of the woman's intravenous fluid

d. Continue to observe and record the normal pattern - ....ANSWER...d. Continue to observe and record the normal pattern

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Free PDF 2026 NCC High Hit-Rate EFM: Certification Certified - Electronic Fetal Monitoring Dumps

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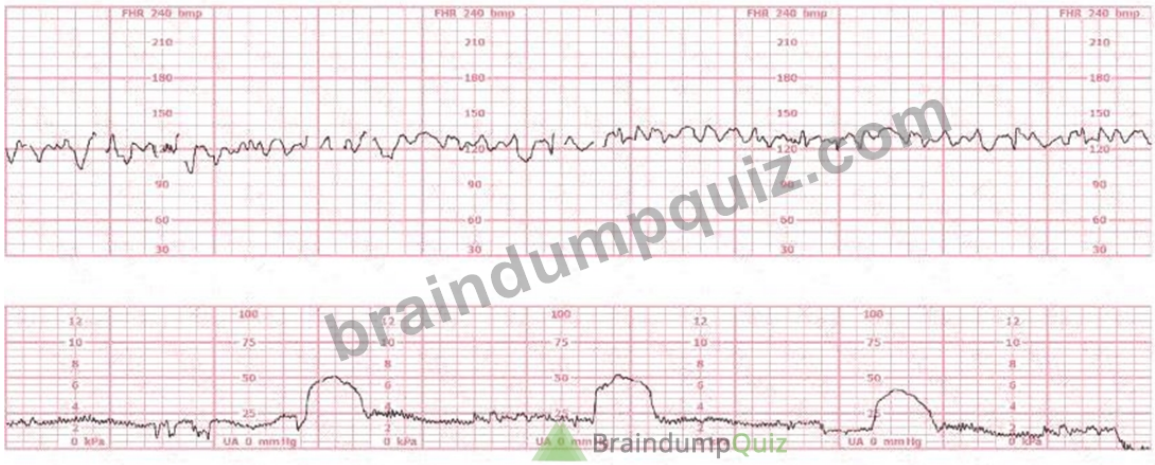
NCC Certified - Electronic Fetal Monitoring Sample Questions (Q86-Q91):

NEW QUESTION # 86
A woman at 34-weeks gestation is in active labor after spontaneous rupture of membranes.
Accelerations should be documented as



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- 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 # 87
(Full question)
Spontaneous fetal heart rate accelerations indicate

- A. dominance of the fetal sympathetic nervous system
- B. integrated response of the fetal central nervous system
- C. immaturity of the fetal parasympathetic nervous system

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (No URLs):
NCC references (AWHONN, Menihan, Simpson, Creasy & Resnik) consistently state that fetal accelerations are a reassuring sign of intact neurologic function. Accelerations represent the interaction of both the sympathetic and parasympathetic branches moderated through the central nervous system, reflecting effective autonomic regulation.
AWHONN specifically describes fetal accelerations as:
* A maturity marker of CNS function,
* Reflecting vigorous fetal movement,
* Demonstrating adequate oxygenation,
* Indicating a well-oxygenated brainstem and cortex.
Simpson & Miller emphasize that accelerations require both systems to be functioning and respond appropriately, which confirms CNS integration, not sympathetic or parasympathetic dominance alone.
Therefore, spontaneous accelerations indicate an integrated CNS response, making Option C the correct NCC-aligned answer.

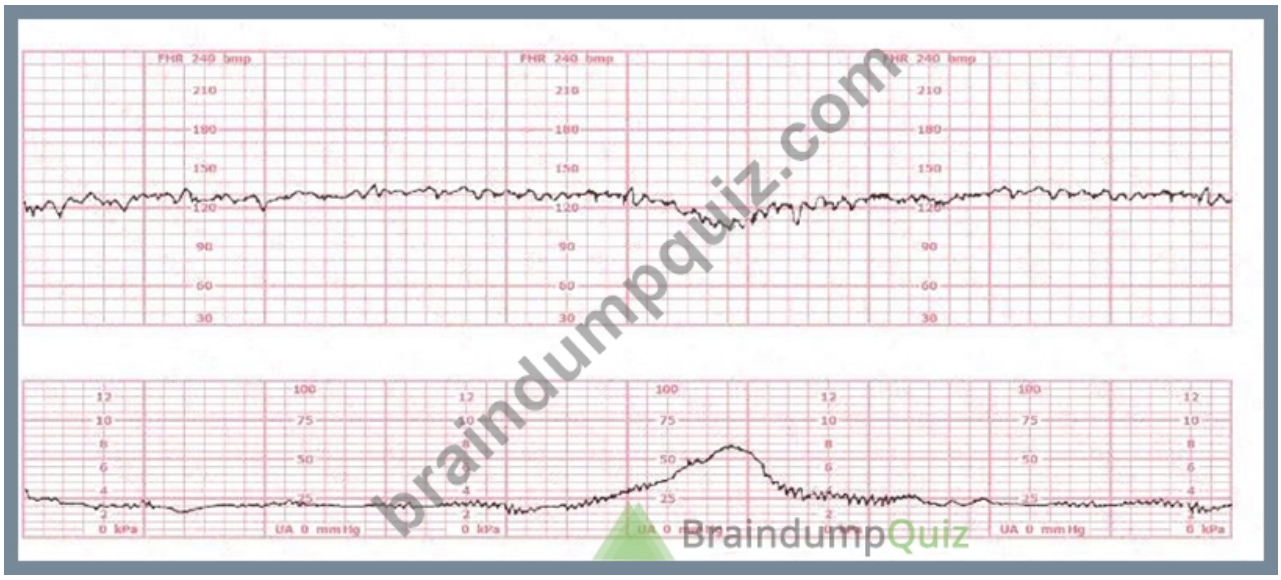
NEW QUESTION # 88
When the fetal heart rate is measured by a Doppler transducer and the intervals between heart beats are persistently identical, this shows as

- A. normal baseline
- B. bradycardia
- C. absent variability

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Variability is created by beat-to-beat differences in fetal cardiac intervals due to autonomic nervous system modulation. AWHONN specifies that absent variability appears as "a near-straight line with minimal or no discernible oscillations," which occurs when all beat intervals are identical.
Menihan notes that Doppler displays variability based on mechanical motion and will show flat, unchanging intervals when fetal autonomic modulation is suppressed, reflecting absent variability.
Bradycardia refers to a baseline <110 bpm and does not describe the uniformity of intervals. A normal baseline may still show variability; it cannot have identical beat-to-beat intervals, as this violates the definition of variability in NICHD terminology.
Simpson & Creehan state that absent variability is a significant marker of impaired fetal oxygenation or CNS depression.
References:
AWHONN - Fetal Heart Monitoring Principles & PracticesMenihan - Electronic Fetal MonitoringSimpson & Creehan - Perinatal NursingCreasy & Resnik - Maternal-Fetal MedicineMiller's Pocket Guide

NEW QUESTION # 89
The pattern on the fetal heart rate tracing shown is likely due to

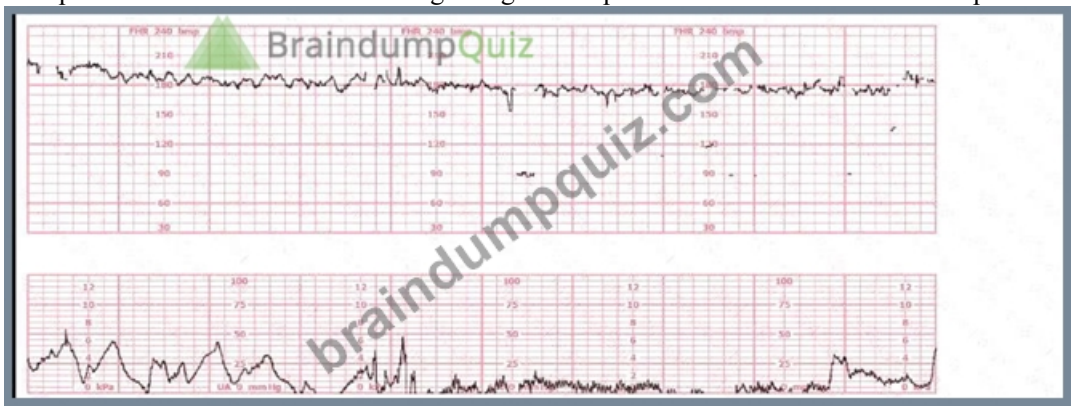


- A. fetal head compression
- B. umbilical cord compression
- C. placental insufficiency

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract Sources:
The tracing demonstrates an abrupt-onset, sharp, V-shaped deceleration, occurring simultaneously with or slightly after a contraction-classic for variable decelerations, which are caused by umbilical cord compression.
According to AWHONN Fetal Heart Monitoring Principles & Practices, variable decelerations are defined by:
* "Abrupt decreases in FHR below baseline of at least 15 bpm, lasting at least 15 seconds and less than 2 minutes."
* "Most commonly associated with umbilical cord compression, whether transient or recurrent." Physiology reference (Simpson & Miller, Pocket Guide):
* Compression of the umbilical vein causes a brief acceleration.
* Compression of the umbilical arteries triggers a vagal response, producing a rapid deceleration.
* This creates the characteristic sharp 'V', 'U', or 'W' shape on the monitor.
Placental insufficiency (Choice B) produces late decelerations, which are gradual, not abrupt.
Fetal head compression (Choice A) produces early decelerations, which mirror contractions and have a gradual pattern.
Thus, the tracing is most consistent with variable decelerations caused by umbilical cord compression.
References:AWHONN Fetal Heart Monitoring Principles & Practices;Simpson - Fetal Monitoring;Menihan - Electronic Fetal Monitoring;Miller's EFM Pocket Guide;NCC C-EFM Content Outline - Pattern Recognition Domain.

NEW QUESTION # 90
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 # 91
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