

# New EFM Test Vce Free - Latest EFM Test Answers

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## NCC EFM test 1

Variable decelerations are thought to be caused by:

- A. Fetal head compression
- B. Umbilical cord compression
- C. Uteroplacental insufficiency - correct answer B. Umbilical cord compression

An appropriate treatment for recurrent variable decelerations with moderate variability during second stage pushing is:

- A. Amnioinfusion
- B. Modification of pushing efforts
- C. Oxygen at 10 liters per nonrebreather face mask. - correct answer B. Modification of pushing efforts

The Primary purpose of the use of electronic fetal monitoring is to:

- A. Determine if the fetus is well oxygenated
- B. Document fetal status throughout labor
- C. Identify the fetus at risk - correct answer C. Identify the fetus at risk

An EFM tracing with fetal heart rate of 170 beats per minute and moderate variability would be classified as:

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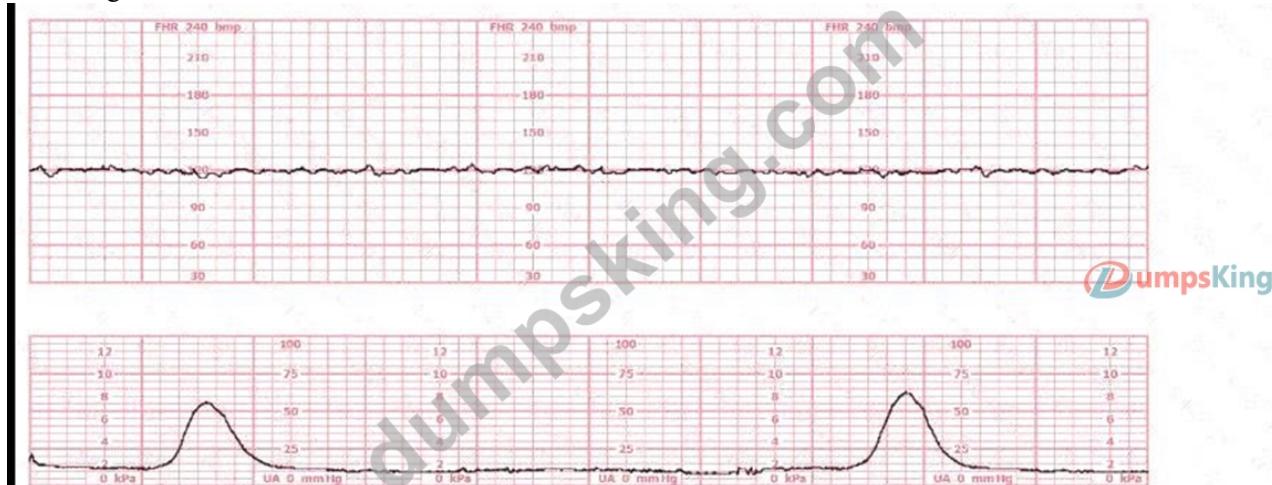
## Latest NCC EFM Test Answers - Valid EFM Test Question

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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q100-Q105):

### NEW QUESTION # 100

This tracing reflects:



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

**Answer: B**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

In NCC C-EFM interpretation, classification of a fetal heart tracing is based on NICHD's three-tier system:

Category I, II, and III. Category III represents an abnormal tracing requiring immediate evaluation and prompt intervention.

Key findings in this tracing:

\* Baseline: Baseline is approximately 140 bpm, within the normal range (110-160 bpm). Baseline alone does not determine category.

\* Variability: The tracing shows absent variability:

\* No beat-to-beat oscillations

\* Flat, minimal fluctuation: NICHD and NCC define absent variability as amplitude range undetectable.

\* Accelerations: No accelerations are present.

\* Decelerations: The strip does not show decelerations or bradycardia. However, absent variability alone with no accelerations for 20 minutes is highly concerning.

Category Classification per NICHD/NCC:

Category III criteria include ANY of the following:

\* Absent variability with recurrent late decelerations

\* Absent variability with recurrent variable decelerations

\* Absent variability with bradycardia

\* Sinusoidal pattern

Also recognized as Category III:

\* Persistent absent variability lasting ≥ 20 minutes with no accelerations, which is strongly suggestive of fetal acidemia when sustained.

This tracing shows:

\* Absent variability (flat line)

\* No accelerations

\* Persisting over an extended period

Under NCC and AWHONN guidance:

A persistently flat tracing must be classified as Category III unless proven otherwise (e.g., fetal sleep, maternal medications), and it requires immediate intrauterine resuscitation and evaluation for potential expedited delivery.

Why Category I is NOT correct:

Category I requires:

\* Moderate variability

\* No late or variable decelerations: This tracing does not have moderate variability.

Why Category II is NOT correct:

Category II includes minimal variability, marked variability, intermittent variables/lates, absence of accelerations after stimulation.

This tracing is worse than Category II because variability is absent, not minimal.

Thus, the tracing fits Category III.

References: NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Three-Tier FHR Interpretation System; 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 # 101

A woman is being induced with oxytocin. The tracing shown is representative of 20 minutes. Based on this tracing, the next step would be to:



- A. Proceed to operative birth
- B. Discontinue oxytocin**
- C. Place a spiral electrode

**Answer: B**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

Evaluation of a tracing during oxytocin induction requires analysis of fetal status (baseline, variability, accelerations, decelerations) and uterine activity, with attention to tachysystole and fetal intolerance. NCC, AWHONN, Miller, Menihan, Simpson, and the NICHD guidelines all emphasize that oxytocin must be adjusted based on fetal response and contraction frequency.

Baseline:

The fetal heart rate baseline is approximately 150 bpm, which is within the normal range of 110-160 bpm.

Variability:

The tracing shows minimal variability (approximately 1-4 bpm amplitude). Minimal variability for a sustained period is categorized as a Category II pattern under NCC/NICHD classification.

Accelerations:

No accelerations are present during the 20-minute representative segment.

Decelerations:

There are no recurrent variable, no recurrent late, and no prolonged decelerations.

Uterine Activity:

The tracing shows very frequent contractions—approximately every 1½ to 2 minutes, which meets the NCC definition of tachysystole when averaged over 10 minutes (more than 5 contractions in 10 minutes).

According to NCC and AWHONN standards, when tachysystole is present with minimal variability, oxytocin must be reduced or discontinued even in the absence of late decelerations.

Clinical decision-making (per NCC principles):

NCC emphasizes that management of Category II patterns during induction starts with intrauterine resuscitative measures, including decreasing or stopping oxytocin when uterine activity is excessive or fetal response is suboptimal. Minimal variability with tachysystole requires correction of uterine stimulation before escalating to invasive monitoring or considering operative birth.

Option B (place a spiral electrode) is not indicated because the pattern is clearly visible and the priority is correcting uterine overstimulation, not refining the tracing.

Option C (operative birth) is not indicated; there is no Category III pattern or recurrent decelerations.

Option A (discontinue oxytocin) is the correct first-line action according to NCC-aligned guidelines when tachysystole and minimal variability occur.

References:

NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Three-Tier FHR Interpretation System; 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 # 102

This is a fetal heart rate tracing of a multiparous woman whose cervix is 7 cm dilated on admission. The most likely cause for this pattern is:



- A. Tachysystole
- B. Rapid fetal descent
- C. Placental abruption

**Answer: A**

**Explanation:**

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

The tracing shows a clear relationship between uterine activity and fetal heart rate changes:

\* The uterine activity strip demonstrates very frequent contractions with little resting time between them, exceeding five contractions in 10 minutes, averaged over a 30-minute window.

\* NCC and NICHD define tachysystole as "more than 5 contractions in 10 minutes, averaged over 30 minutes, regardless of whether the labor is spontaneous or stimulated." As uterine activity intensifies and becomes excessively frequent, the fetal heart rate strip begins to show:

- \* Progressive decrease in baseline
- \* Recurrent decelerations with gradual onset and recovery
- \* Reduced variability in the latter portion of the strip

This pattern is consistent with uteroplacental insufficiency caused by excessive uterine activity (tachysystole). NCC and AWHONN emphasize that tachysystole can result in decreased uterine blood flow and fetal oxygenation, leading to late or prolonged decelerations and eventual bradycardia if not corrected.

Why the other options are less likely:

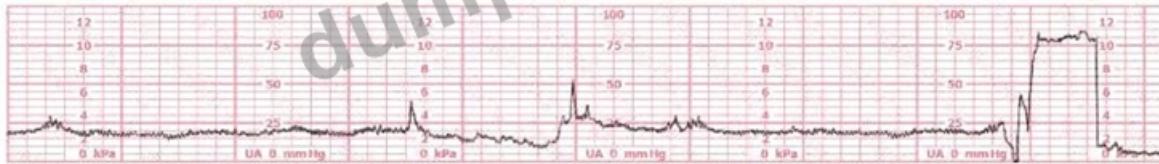
- \* A. Placental abruptionTypically associated with maternal symptoms (pain, vaginal bleeding, firm /boardlike uterus) and often a sustained increase in resting tone or a hypertonic contraction, not simply very frequent contractions. These maternal findings are not described in the vignette.
- \* B. Rapid fetal descentUsually causes variable or early decelerations related to head compression, but the tocodynamometer would not necessarily show this degree of contraction frequency. The lower strip here clearly highlights excessive contractions as the primary problem.

Thus, the tracing's FHR abnormalities are best explained by tachysystole, making C. Tachysystole the most appropriate answer.

References:NCC C-EFM Candidate Guide (2025); NCC Content Outline - Pattern Recognition and Intervention; NICHD Three-Tier FHR Interpretation System; 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 # 103

Based on the tracing shown, the first action should be to



- A. assess maternal temperature
- B. administer vibroacoustic stimulation
- C. palpate for contractions

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (No URLs or Links):

According to the NCC C-EFM exam outline and AWHONN Fetal Heart Monitoring Principles (2022), the first step when evaluating a concerning fetal heart rate pattern is to verify uterine activity, because the fetal response is often directly associated with contraction frequency, strength, or tachysystole. AWHONN states that "the clinician must confirm maternal-fetal physiology and uterine activity by palpation when interpreting any FHR pattern, as tocodynamometry may under- or overestimate uterine pressure." Menihan's Electronic Fetal Monitoring further emphasizes: "Always validate the contraction pattern via maternal abdominal palpation before proceeding with additional interventions." The tracing shows a late-appearing deceleration pattern with uncertain contraction correlation because the external toco waveform is inadequate (flat or poorly recorded). Before determining whether the decelerations are early, late, or variable, the clinician must confirm whether contractions are present, absent, or excessive. This step is listed as a core competency under Pattern Recognition & Intervention in the NCC Candidate Guide.

Therefore, palpating for contractions is the required first intervention.

References: AWHONN Fetal Heart Monitoring (2022-2024 Edition) Menihan: Electronic Fetal Monitoring Simpson & Creasy: Perinatal Nursing / Maternal-Fetal Physiology NCC C-EFM Content Outline - Pattern Recognition and Intervention Domain

#### NEW QUESTION # 104

Maternal-fetal oxygen transfer takes place in the:

- A. Intervillous space
- B. Umbilical vein
- C. Spiral arteries

**Answer: A**

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Physiologic Sources:

Oxygen transfer occurs at the maternal-fetal interface within the intervillous space, where:

- \* Maternal blood from the spiral arteries bathes the chorionic villi
- \* Diffusion occurs between maternal blood and fetal capillary beds
- \* Oxygen then travels through fetal circulation via the umbilical vein

Thus:

- \* Intervillous space = site of gas exchange
- \* Spiral arteries = deliver maternal blood to that space
- \* Umbilical vein = fetal vessel carrying oxygenated blood after exchange has occurred

Correct answer: A. Intervillous space

References: NCC Physiology Domain; AWHONN FHMPP; Creasy & Resnik; Simpson & Creehan.

## NEW QUESTION # 105

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