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Centre Number: KZ001 Date: [Redacted] Candidate Number: [Redacted]

Candidate Details

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Date of Birth: 27/06/2004 Sex (M/F): M Scheme Code: Private Candidate

Country or Region of Origin: [Redacted]
Country of Nationality: KAZAKHSTAN
First Language: KAZAKH

Test Results

Listening: 9.0 Reading: 9.0 Writing: 7.0 Speaking: 6.5 Overall Band Score: 8.0 CEFR Level: C1

Administrator Comments

Centre stamp: BRITISH COUNCIL
Validation stamp: IELTS

Administrator's Signature: [Redacted]

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NCC EFM Exam Syllabus Topics:

Section	Weight	Objectives
Pattern Recognition and Intervention	70%	- Fetal Heart Rate Patterns • 1. Baseline Variability • 2. Accelerations and Decelerations • 3. Sinusoidal Patterns - Maternal and Fetal Complications • 1. Tachysystole • 2. Intrauterine Resuscitation • 3. Fetal Dysrhythmias

Physiology	11%	- Maternal-Fetal Physiology 1. Uteroplacental Circulation 2. Fetal Oxygenation 3. Fetal Heart Rate Regulation
Professional Issues	5%	- Clinical Practice and Safety 1. Quality Improvement 2. Legal and Ethical Issues 3. Patient Safety
Fetal Assessment Methods	9%	- Assessment Techniques 1. Fetal Movement Assessment 2. Cord Blood and Acid-Base Analysis 3. Contraction Stress Testing
Electronic Monitoring Equipment	5%	- Monitoring Systems 1. Internal Monitoring 2. Equipment Troubleshooting 3. External Monitoring

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Exam EFM Objectives Pdf, Exam EFM Cram Review

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q53-Q58):

NEW QUESTION # 53

A woman in active labor at 8 cm experiences spontaneous rupture of membranes and acute bright red vaginal bleeding. The uterus is soft and nontender to palpation. The fetal monitor tracing has been normal and now shows tachycardia followed by bradycardia with minimal variability. The maternal blood pressure is 130/76 mm Hg, and the pulse is 86 beats per minute. The most likely cause of these findings is:

- A. Abruption placenta
- B. Ruptured vasa previa
- C. Placenta previa

Answer: B

Explanation:

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

When bright red vaginal bleeding occurs at the moment of membrane rupture, accompanied by an acute, severe fetal heart rate deterioration, NCC sources emphasize considering conditions causing fetal hemorrhage rather than maternal instability.

The key features in this scenario:

* Timing: Bleeding occurs immediately with spontaneous rupture of membranes-this is classic for vasa previa rupture, where fetal vessels traverse membranes and are torn when the membranes rupture.

* Bleeding characteristics: Bleeding is acute, bright red, and sudden. In vasa previa, the blood observed vaginally is fetal blood, not maternal blood.

* Uterine exam: The uterus is soft and nontender, which strongly argues against abruption placenta, where the uterus is typically firm, rigid, or painful.

* Maternal vital signs: Maternal blood pressure and pulse are normal, indicating no maternal hypovolemia. In placental abruption or placenta previa with significant maternal bleeding, maternal vitals are often abnormal. Here, the mother is stable, meaning the blood is

not maternal-supporting fetal vessel rupture.

* Fetal heart rate pattern:

* Initial tachycardia, followed by

* Bradycardia with minimal variability Such a pattern is consistent with acute fetal blood loss, which rapidly leads to fetal hypovolemia and hypoxia.

* Differential based on NCC-aligned physiology:

A). Abruptio placenta - NOT supported

Typically presents with:

* Painful bleeding

* Firm, tender uterus

* Maternal tachycardia

* Uterine irritability None of these are present.

B). Placenta previa - NOT supported

Classically painless bright red bleeding before or early in labor, not triggered by membrane rupture.

Fetal compromise is less sudden unless maternal shock occurs, which is not the case here.

C). Ruptured vasa previa - CORRECT

Defined by:

* Painless, sudden bright red bleeding at ROM

* Normal maternal vital signs

* Rapid fetal deterioration (tachycardia # bradycardia # minimal variability)

* Soft, nontender uterus This fits the scenario exactly.

Therefore, the most likely cause is ruptured vasa previa, a recognized obstetric emergency described across AWHONN, NCC C-EFM references, and maternal-fetal physiology texts such as Menihan and Creasy & Resnik.

References: NCC C-EFM Candidate Guide (2025); NCC Content Outline; 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 # 54

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

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

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 # 55

Nonstress testing is used more frequently for antepartum testing than contraction stress testing because contraction stress testing has a:

- **A. Higher frequency of equivocal test results**
- B. Low predictability of fetal well-being within 7 days of a negative test
- C. Limited reporting option for the compromised fetus

Answer: A

Explanation:

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

NCC and AWHONN explain that Contraction Stress Testing (CST):

- * Has a higher rate of equivocal ("equivocal-suspicious" or "equivocal-hyperstimulation") results
- * Frequently must be repeated or replaced with other tests
- * Requires inducing contractions, which carries risk (hyperstimulation, preterm labor, uterine rupture in scarred uterus) NST is used more commonly because it is:
- * Noninvasive
- * Easier to perform
- * Has fewer contraindications
- * Has a lower rate of equivocal results

Why the others are incorrect:

- * B - CST does detect fetal compromise reliably and is NOT limited in its reporting structure.
 - * C - A negative CST actually has very high negative predictive value for 7 days, making this answer incorrect.
- Thus the correct choice is A. Higher frequency of equivocal results.

References: NCC C-EFM Candidate Guide; AWHONN; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 56

(Full question statement)

A woman at 39-weeks gestation is in labor, progressing normally. The baseline fetal heart rate has increased from 125 to 150 beats per minute over the last hour with moderate variability. What is the next step?

- A. Initiate antibiotic therapy
- B. Perform an ultrasound
- C. Continue to observe

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Without Links:

NCC-recommended references (Simpson, AWHONN FHM, Creasy & Resnik) note that baseline increases within the normal range (110-160 bpm) accompanied by moderate variability are typically benign. Mild physiologic causes-maternal activity, fetal stimulation, or normal sympathetic activation-may transiently raise baseline FHR.

AWHONN stresses that intervention is required only when tachycardia exceeds 160 bpm or when variability is minimal/absent or accompanied by recurrent decelerations.

Here, the baseline increase to 150 bpm remains within normal limits and is paired with moderate variability, which the NCC recognizes as the strongest indicator of adequate fetal oxygenation.

Therefore, evaluation is complete, and continued observation is the appropriate course.

NEW QUESTION # 57

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

Answer: B

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 abruption Typically 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 descent Usually 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 # 58

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The cost of registering for a certification Certified - Electronic Fetal Monitoring (EFM) exam is quite expensive, ranging between \$100 and \$1000. After paying such an amount, the candidate is sure to be on a tight budget. TrainingDump provides Certified - Electronic Fetal Monitoring (EFM) preparation material at very low prices compared to other platforms. We also assure you that the amount will not be wasted and you will not have to pay for the Certified - Electronic Fetal Monitoring (EFM) certification test for a second time.

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