

EFM Reliable Exam Test, Reliable EFM Exam Practice

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

Page 1 | 12

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Actual NCC EFM Exam Questions In Different Formats

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q69-Q74):

NEW QUESTION # 69

A woman is admitted at 41-weeks gestation for fetal evaluation following a motor vehicle accident. She reports that she hit her abdomen on the steering wheel. The underlying physiology of the tracing is most likely:

- A. Fetal trauma
- **B. Placental abruption**
- C. Cord accident

Answer: B

Explanation:

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

This tracing shows recurrent late decelerations, decreased variability, and subtle baseline shifts- findings that strongly correspond to uteroplacental insufficiency. In trauma cases, NCC emphasizes that placental abruption is the most common fetal complication, caused by shearing forces separating the placenta from the uterine wall.

Key physiologic points per NCC/AWHONN/Menihan:

- * Maternal blunt abdominal trauma frequently leads to partial or concealed abruption.
- * Abruption produces decreased uteroplacental blood flow, resulting in:
 - * Late decelerations
 - * Minimal/absent variability
 - * Baseline shifts or instability

Cord accident (option A) typically produces variable decelerations, not late-pattern decelerations.

Fetal trauma (option B) is extremely rare and does not produce a consistent deceleration pattern.

Thus, the physiology most consistent with this tracing and mechanism of injury is placental abruption.

References: NCC C-EFM Candidate Guide (2025); NCC Physiology Domain; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 70

Prenatal diagnosis shows that a fetus has renal agenesis. During delivery, what type of electronic fetal heart rate pattern is most likely to be seen due to a common complication associated with this syndrome?

- **A. Variable decelerations**
- B. Fetal heart block
- C. Late decelerations

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Renal agenesis # severe oligohydramnios (due to absent fetal urine production).

Oligohydramnios causes:

- * Cord compression
- * Recurrent variable decelerations
- * Possible prolonged decels from cord entrapment

This is one of the hallmark FHR complications in renal agenesis.

Why the other options are incorrect:

- * A. Heart block - associated with maternal autoimmune antibodies, not renal anomalies.
- * B. Late decelerations - associated with uteroplacental insufficiency, not fluid deficiency.

Correct answer: C. Variable decelerations.

References: NCC Physiology & Pattern Recognition; AWHONN FHMP; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 71

A 30-minute tracing with moderate variability, accelerations, and one variable deceleration would be classified as:

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

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

NICHD/NCC criteria:

Category I must have ALL of the following:

- * Baseline 110-160 bpm
- * Moderate variability
- * No late or variable decelerations
- * Early decelerations may be present or absent
- * Accelerations may be present or absent

Because this tracing has one variable deceleration, it fails Category I criterion ("no late or variable decelerations").

Category III requires:

- * Absent variability with recurrent late decels, recurrent variables, or bradycardia, or
- * Sinusoidal pattern

Those findings are not present.

Therefore, any tracing that:

- * Has moderate variability and accelerations,
- * But includes a variable deceleration, and
- * Does not meet Category III criteria

...falls into the Category II (indeterminate) group.

Correct classification: B. Category II.

References: NCC C-EFM Candidate Guide; NICHD Three-Tier FHR Interpretation System; AWHONN FHMPP; Menihan; Simpson & Creehan.

NEW QUESTION # 72

Fetal cardiac output is essentially dependent on the fetal:

- A. Baroreceptors
- B. Activity
- C. Heart rate

Answer: C

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Because the fetal myocardium is immature, it has:

- * Limited ability to increase stroke volume
- * Limited ability to increase contractility

Therefore, fetal cardiac output (CO) is almost entirely dependent on heart rate.

NCC and AWHONN physiology describe:

- * $CO = \text{stroke volume} \times \text{heart rate}$
- * In the fetus, stroke volume is relatively fixed
- * Therefore, changes in HR directly affect cardiac output
- * Tachycardia # increases CO
- * Bradycardia # decreases CO # decreased perfusion and oxygen delivery

Why the other options are incorrect:

- * A. Activity does not fundamentally determine CO.
- * B. Baroreceptors regulate HR reflexively but are not the primary determinant of cardiac output.

Correct answer: C. Heart rate

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

NEW QUESTION # 73

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. Placenta previa
- B. Abruptio placenta
- C. Ruptured vasa previa

Answer: C

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 abruptio 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 # 74

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