Epic Inpatient Module 100 (IMP 100) Practice Exam (Sample)

Study Guide

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Questions

1. How can a clinician open a patient's chart in the EPIC system?

- **A. Right-click on the patient's name**
- **B. Select the patient and press 'Open'**
- **C. Double-click the patient from Patient Lists**
- **D. Use the search function to find the chart**

2. What is defined as the Principal problem?

- **A. The most recent diagnosis identified in the patient's record**
- **B. The secondary issue that needs attention during hospitalization**
- **C. The main reason for the patient’s hospitalization**
- **D. The problem that has the most severe symptoms**

3. What may prompt a nurse to pull a medication from an ADS cabinet on override?

- **A. The medication is scheduled for the next shift**
- **B. No order has been entered for the medication into Epic**
- **C. The medication has been verified by pharmacy**
- **D. All orders have been canceled**

4. What are the tabs along the left of the screen in a patient's chart called?

- **A. Sections**
- **B. Functions**
- **C. Activities**
- **D. Modules**

5. What is typically saved in the Work List after logging out?

- **A. Filters and tasks**
- **B. Last view selected by the user**
- **C. All patient settings**
- **D. Customizations made by the user**

6. On which tab can you document the progress of education provided to the patient?

- **A. The Documentation tab**
- **B. The Patient Overview tab**
- **C. The Education tab**
- **D. The Care Plan tab**

7. In the medication reconciliation navigator, which section helps determine the status of a home medication for admission?

- **A. Review Home Medications**
- **B. Reconcile Home Medications**
- **C. Medication Orders**
- **D. Patient History**

8. What is a key feature of the Due Meds report compared to the Work List?

- **A. Allows for viewing all tasks simultaneously**
- **B. Displays medications due within the current shift for one patient**
- **C. Provides options to document without opening patient charts**
- **D. Shows scheduled times for all medications**

9. Which action needs to be performed to create a new order for home medications?

- **A. Contact the pharmacy directly**
- **B. Navigate to the patient's allergies tab**
- **C. Use the Home Meds tab to reorder**
- **D. Consult with nursing staff about the medication**

10. What is the significance of signing and holding an order for a patient?

- **A. The order is automatically released to pharmacy**
- **B. The order is authorized but not active until further notice**
- **C. The order is canceled until the patient is discharged**
- **D. The order is finalized and goes into effect immediately**

Answers

1. C
2. C
3. B
4. C
5. B
6. C
7. B
8. B
9. C
10. B

Explanations

1. How can a clinician open a patient's chart in the EPIC system?

A. Right-click on the patient's name

B. Select the patient and press 'Open'

C. Double-click the patient from Patient Lists

D. Use the search function to find the chart

To access a patient's chart in the EPIC system, a clinician can double-click the patient's name from the Patient Lists. This action directly opens the patient's chart and provides immediate access to their information, which is essential for clinical decision-making and chart review. This method is efficient because it allows for quick navigation without additional steps or searches. Using the search function, while it can also lead to patient chart access, may involve more time, particularly if the clinician needs to enter specific identifiers. Selecting the patient and pressing 'Open' is another method, but it can be less intuitive than simply double-clicking. Right-clicking may not be a standardized action for opening charts and could lead to confusion regarding available options, making it less effective compared to direct double-clicking in the Patient Lists.

2. What is defined as the Principal problem?

A. The most recent diagnosis identified in the patient's record

B. The secondary issue that needs attention during hospitalization

C. The main reason for the patient's hospitalization

D. The problem that has the most severe symptoms

The Principal problem is defined as the main reason for the patient's hospitalization. This designation is critical in clinical documentation as it helps healthcare providers focus on the primary issue affecting the patient's health that necessitated their admission. This principal diagnosis serves as the guiding factor for treatment planning, resource allocation, and effective communication among the care team. By accurately identifying the principal problem, providers can ensure that the most pressing health concerns are addressed first, leading to better outcomes. Understanding this concept is foundational in the Epic Inpatient Module, as it shapes how patient care is structured and prioritized during their stay. The principal problem plays a vital role in the overall clinical narrative, impacting everything from diagnosis coding to billing processes.

3. What may prompt a nurse to pull a medication from an ADS cabinet on override?

A. The medication is scheduled for the next shift

B. No order has been entered for the medication into Epic

C. The medication has been verified by pharmacy

D. All orders have been canceled

When a nurse pulls a medication from an Automated Dispensing System (ADS) on override, it usually occurs in a situation where there is an urgent need for a medication that has not yet been officially ordered or documented in the electronic health record (EHR), such as Epic. In this scenario, option B is correct because it indicates that there is no order entered for the medication in Epic, suggesting an immediate clinical need that cannot wait for the standard ordering process. Typically, overrides are intended for emergent situations where a patient requires medication quickly, and waiting for a formal order could jeopardize patient safety. This highlights the nurse's clinical judgment in urgent care scenarios while also showcasing the importance of proper documentation following the override to ensure compliance with regulatory standards and medication safety protocols. In contrast, the other options do not align with the rationale for using an override. For instance, if the medication is scheduled for the next shift, it would be inappropriate to pull it on override, as there is no pressing need for immediate administration. Likewise, if the medication has already been verified by pharmacy, it would imply that there is an accurate order in place, reducing the necessity for an override. Additionally, pulling a medication when all orders have been canceled contradicts the

4. What are the tabs along the left of the screen in a patient's chart called?

A. Sections

B. Functions

C. Activities

D. Modules

The tabs along the left of the screen in a patient's chart are referred to as "Activities." This terminology is significant as it reflects the various interactive elements that allow users to navigate through different parts of the patient's record seamlessly. Each activity represents a specific function or task that can be performed, such as viewing medications, lab results, or patient history. This organized structure helps clinicians and staff quickly access relevant information and engage with the patient's care efficiently. Understanding this terminology is vital for effective use of the system, as it enhances a user's ability to locate necessary information and perform tasks in a logical, streamlined manner.

5. What is typically saved in the Work List after logging out?

A. Filters and tasks

B. Last view selected by the user

C. All patient settings

D. Customizations made by the user

The aspect that is saved in the Work List after logging out is the last view selected by the user. This feature is designed to enhance user experience by allowing individuals to return to their preferred work context upon logging back in. When a user logs out, the system remembers their last view, which may include the specific layout, filters, or sections of the Work List that were last accessed. This capability is particularly useful in a healthcare setting where users need to efficiently navigate through patient information and tasks. It streamlines the process, enabling quicker access to frequently used views, thereby promoting productivity and reducing the time it takes to reconfigure the system upon return. Other options, while they might seem relevant, do not typically persist through a logout. For instance, filters and tasks may vary with each session based on the individual needs of the user at that moment. Similarly, while some patient settings can be customizable, they are not necessarily saved at the session logout level. Customizations made by the user may affect the interface during a session but are not guaranteed to be stored in the Work List after logging out, as they often pertain to the user profile settings rather than the Work List itself.

6. On which tab can you document the progress of education provided to the patient?

A. The Documentation tab

B. The Patient Overview tab

C. The Education tab

D. The Care Plan tab

The Education tab is specifically designed for documenting educational interactions and progress made with the patient. This tab allows healthcare providers to record details about the instructional materials provided, the topics covered, and the patient's understanding and engagement with the information shared. It's a designated area focused solely on education, ensuring that all relevant information regarding the patient's learning experience is organized and easily accessible. In a healthcare setting, documenting educational efforts is crucial for continuity of care and evaluating patient comprehension and readiness to implement self-care strategies. The other tabs serve different purposes: the Documentation tab focuses on various forms of clinical notes, the Patient Overview tab provides a summary of the patient's overall status, and the Care Plan tab outlines the treatment strategies and goals. While these other sections may contain references to education, the Education tab is dedicated to capturing the specifics of educational interactions. Therefore, it is the most appropriate choice for this aspect of patient documentation.

7. In the medication reconciliation navigator, which section helps determine the status of a home medication for admission?

A. Review Home Medications

B. Reconcile Home Medications

C. Medication Orders

D. Patient History

The choice that best addresses the status of a home medication for admission is the section titled "Reconcile Home Medications." This section plays a crucial role in the medication reconciliation process, as it allows healthcare providers to compare a patient's current medication list, which includes home medications, with the medications prescribed during the hospital admission. In practice, reconciling home medications ensures that any discrepancies are identified and addressed, thereby minimizing the risk of medication errors. This process not only confirms what the patient has been taking before admission but also integrates this information into the new treatment plan. The other sections serve different purposes. For instance, "Review Home Medications" typically focuses on displaying the list of medications a patient was taking prior to admission without directly engaging in the reconciliation process. "Medication Orders" refers to the orders for medications that are prescribed during the hospital stay, while "Patient History" includes broader information about the patient's background and medical conditions but does not specifically address the current status of home medications in the context of an admission. Thus, "Reconcile Home Medications" is the key section that ensures a clear understanding of how home medications fit into the overall treatment plan upon admission.

8. What is a key feature of the Due Meds report compared to the Work List?

A. Allows for viewing all tasks simultaneously

B. Displays medications due within the current shift for one patient

C. Provides options to document without opening patient charts

D. Shows scheduled times for all medications

The Due Meds report is designed specifically to focus on medications that are due within a certain timeframe, particularly within a shift. This is crucial for nursing and clinical staff who need to prioritize medication administration effectively during their shift. By displaying medications due within the current shift for one patient, the report ensures that healthcare providers can quickly access and manage the medications that need immediate attention, thereby improving patient care and safety. This function is particularly beneficial in fast-paced clinical environments, as it allows staff to have a clear view of what they need to administer without being distracted by other tasks or information. This ensures a streamlined workflow focused on urgent medication needs and enhances compliance with medication administration protocols.

9. Which action needs to be performed to create a new order for home medications?

A. Contact the pharmacy directly

B. Navigate to the patient's allergies tab

C. Use the Home Meds tab to reorder

D. Consult with nursing staff about the medication

To create a new order for home medications, utilizing the Home Meds tab is essential. This feature is specifically designed for managing a patient's home medications within the Epic system. By accessing this tab, healthcare providers can view, update, and place orders for medications the patient has been taking prior to or during their hospital stay. This streamlined process ensures that the medications can be accurately documented and ordered according to the patient's needs. Using the Home Meds tab also helps in avoiding potential drug interactions or medication errors by providing a comprehensive overview of the patient's previous medications and any changes that may need to be made. This is a crucial step in maintaining continuity of care and ensuring patient safety. While the other options may involve useful communication or information gathering, they do not directly pertain to the creation of new medication orders within the electronic health record system.

10. What is the significance of signing and holding an order for a patient?

A. The order is automatically released to pharmacy

B. The order is authorized but not active until further notice

C. The order is canceled until the patient is discharged

D. The order is finalized and goes into effect immediately

Signing and holding an order for a patient is significant because it indicates that the order has been authorized by the clinician but is not yet active. This implies that while the healthcare provider has approved the order, there is a deliberate decision to pause its implementation until certain conditions are met or further information is available. This can be critical for ensuring that patients do not receive unnecessary medications or treatments that may not be appropriate given their current clinical status. The option that emphasizes the authorization without activation reflects a controlled approach to patient care, allowing for medical decisions to be based on ongoing assessments and potentially changing clinical situations. It also ensures that there is clear communication among the healthcare team regarding the status of the order, which is essential for maintaining high standards of patient safety and care coordination.