

EPIC INPATIENT MODULE 100 (IMP 100) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the effect of clicking the check box in a BestPractice Advisory?**
 - A. It confirms the action is mandatory
 - B. It clears the suggestion to proceed without it
 - C. It sends a notification to the pharmacy
 - D. It generates a report for future audits
- 2. What should clerical staff do if they encounter uncertainties about medication names?**
 - A. Consult the physician directly
 - B. Type 'Unknown' in the search field
 - C. Ignore the patient's statement
 - D. Assume no medication is being taken
- 3. What key information does the "Discharge Summary" provide in Epic?**
 - A. Instructions for staff about work schedules
 - B. Clinical findings and recommendations for ongoing care
 - C. A list of all medications prescribed
 - D. Patient billing information and payment status
- 4. What indicates if there are values hidden within a time interval in accordion reports?**
 - A. A red triangle appears
 - B. An asterisk shows next to the value
 - C. An ellipsis is displayed
 - D. A plus sign appears next to the value
- 5. How can you tell there is an abnormal value within a specified time interval in accordion reports?**
 - A. It is highlighted in yellow
 - B. It is displayed in bold text
 - C. There is a red exclamation point next to the value
 - D. The value is underlined

- 6. What information must be included at the end of a sticky note?**
- A. The patient's ID and time
 - B. Your name and the date you are writing the note
 - C. Type of task and deadline
 - D. Department and shift time
- 7. What does "Incident Reporting" entail in Epic?**
- A. Documenting successful treatments
 - B. Managing patient complaints and grievances
 - C. Documenting and managing occurrences of adverse events
 - D. Maintaining staff performance records
- 8. How can healthcare professionals flag important patient information in Epic?**
- A. By creating a physical copy of the records
 - B. Using color-coded alerts or custom tags
 - C. Through verbal communication only
 - D. By sending emails to the care team
- 9. How can users archive old patient records in Epic?**
- A. Through patient requests only
 - B. Using designated report functions
 - C. By deleting records manually
 - D. By contacting technical support
- 10. How can a nurse ensure effective communication regarding a documented goal?**
- A. Share the documentation with team members
 - B. Keep the documentation confidential
 - C. Limit discussions to immediate supervision
 - D. Only distribute to physicians

Answers

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

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Explanations

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1. What is the effect of clicking the check box in a BestPractice Advisory?

- A. It confirms the action is mandatory
- B. It clears the suggestion to proceed without it**
- C. It sends a notification to the pharmacy
- D. It generates a report for future audits

Clicking the check box in a BestPractice Advisory serves the purpose of indicating that the clinician has acknowledged or reviewed the advisory's suggestion and has chosen to clear the suggestion. This action allows the clinician to proceed without adhering to the recommendation provided in the advisory. The BestPractice Advisory is designed to enhance clinical decision-making; therefore, when a clinician decides to check the box, they are signifying that they are aware of the advisory but have made a decision to proceed differently. In a clinical setting, this functionality is important as it maintains a record of the clinician's acknowledgment and decision-making process, potentially impacting care delivery and ensuring that there is a documented rationale for moving forward without the suggested action.

2. What should clerical staff do if they encounter uncertainties about medication names?

- A. Consult the physician directly
- B. Type 'Unknown' in the search field**
- C. Ignore the patient's statement
- D. Assume no medication is being taken

In the scenario where clerical staff encounter uncertainties about medication names, the best course of action is to type 'Unknown' in the search field. This approach allows the staff to document the uncertainty without making assumptions or risking errors in patient medication records. By entering 'Unknown,' it signals to other healthcare providers that there is a need for further investigation or clarification regarding the medication in question. Utilizing this method also helps maintain the integrity of the medication list. It ensures that any missing or unclear information is flagged for review, encouraging a thorough follow-up process. This is particularly important in the context of patient safety, as inaccurate medication information can lead to medication errors and adversely affect patient care. Other options, while they may seem plausible, do not provide a systematic or safe means of resolving uncertainties. Consultations with a physician may not always be practical or timely, especially in busy clinical environments. Ignoring the patient's statement or assuming no medication is being taken could lead to critical oversights about a patient's treatment plan. Therefore, opting to use 'Unknown' is a prudent and efficient strategy for addressing uncertainties about medication names.

3. What key information does the "Discharge Summary" provide in Epic?

- A. Instructions for staff about work schedules
- B. Clinical findings and recommendations for ongoing care**
- C. A list of all medications prescribed
- D. Patient billing information and payment status

The "Discharge Summary" in Epic serves as a crucial document that conveys essential clinical information about a patient's care during their hospital stay. This summary typically includes clinical findings, such as the patient's condition at discharge and any pertinent test results. It also provides recommendations for ongoing care, which may include follow-up appointments, referrals to specialists, and information about home care or rehabilitation services. By documenting these clinical insights and suggestions, the Discharge Summary facilitates seamless continuity of care after the patient leaves the hospital. This is vital for ensuring that healthcare providers, whether at a follow-up appointment or in an outpatient setting, are fully informed about the patient's recent health status and treatment plan. In summary, the Discharge Summary effectively bridges the gap between hospital care and further healthcare services, emphasizing its importance in the overall care continuum.

4. What indicates if there are values hidden within a time interval in accordion reports?

- A. A red triangle appears
- B. An asterisk shows next to the value
- C. An ellipsis is displayed
- D. A plus sign appears next to the value**

In accordion reports, the presence of a plus sign next to a value indicates that there are additional values or details hidden within that specific time interval. This visual cue prompts the user to expand the accordion section to reveal more information, facilitating a deeper understanding of the data grouped in that interval. The plus sign acts as an invitation to explore further, highlighting that the data set is not just limited to what is immediately visible. Understanding this feature is crucial for effectively navigating and interpreting accordion reports, as it enables users to access detailed information that might be relevant for analysis or decision-making.

5. How can you tell there is an abnormal value within a specified time interval in accordion reports?

- A. It is highlighted in yellow
- B. It is displayed in bold text
- C. There is a red exclamation point next to the value**
- D. The value is underlined

The correct response regarding identifying abnormal values within a specified time interval in accordion reports is that the abnormal value is indicated by a red exclamation point next to the value. This visual cue is specifically designed to draw the user's attention to values that fall outside of the expected range, facilitating quick recognition and prompting further investigation or action. The use of a red exclamation point effectively communicates urgency and significance to the data, ensuring that healthcare professionals can prioritize these findings in clinical decision-making. By providing such clear indicators, the reports allow for efficient monitoring and management of patient care. Other methods of highlighting values, such as bold text or color highlighting, may provide emphasis, but they do not carry the same distinct implication of abnormality that the red exclamation point offers. Similarly, underlining a value does not commonly suggest deviation or required attention in this context. Overall, the standardized use of symbols like the red exclamation point is a critical feature in enhancing the readability and functionality of clinical reporting tools.

6. What information must be included at the end of a sticky note?

- A. The patient's ID and time
- B. Your name and the date you are writing the note**
- C. Type of task and deadline
- D. Department and shift time

Including your name and the date you are writing the note at the end of a sticky note is essential for ensuring clear communication and accountability in patient care. This practice helps to establish who is responsible for the information contained within the note, allowing for proper follow-up and clarification if needed. Additionally, documenting the date provides context regarding when the information was recorded, which is critical in the healthcare environment where patient conditions and circumstances can change rapidly. Although other options may provide useful information in certain situations, they do not address the fundamental need for identifying the author of the note and the timing of the communication. This is crucial in a collaborative health care setting where multiple providers might interact with the same patient and need clarity regarding who made specific notes and when.

7. What does "Incident Reporting" entail in Epic?

- A. Documenting successful treatments
- B. Managing patient complaints and grievances
- C. Documenting and managing occurrences of adverse events**
- D. Maintaining staff performance records

Incident reporting in Epic encompasses the process of documenting and managing occurrences of adverse events. This is crucial for ensuring patient safety and improving the quality of care. Each incident report serves as a formal record of unexpected events that could potentially harm a patient or compromise the quality of care delivered. By accurately capturing these occurrences, healthcare organizations can analyze trends, identify areas for improvement, enhance training, and develop preventive measures to mitigate future incidents. Through robust documentation and management of adverse events, incident reporting also fosters a culture of transparency and accountability, allowing healthcare facilities to address issues proactively. It is an essential mechanism for continuous quality improvement, ultimately contributing to enhanced patient outcomes and safety in the healthcare environment.

8. How can healthcare professionals flag important patient information in Epic?

- A. By creating a physical copy of the records
- B. Using color-coded alerts or custom tags**
- C. Through verbal communication only
- D. By sending emails to the care team

Healthcare professionals can effectively flag important patient information in Epic by utilizing color-coded alerts or custom tags. This method allows clinicians to visually prioritize critical information directly within the electronic health record (EHR) system. Color-coded alerts can immediately draw attention to specific concerns, such as allergies, critical lab results, or other urgent matters that require prompt action or awareness by the care team. Custom tags can also be tailored to highlight various aspects of a patient's care plan, enhancing communication and awareness among healthcare providers without the need for additional paperwork or manual tracking methods. This approach leverages the capabilities of the EHR to enhance patient safety and streamline workflows, ensuring that important information is readily accessible within the digital record. In contrast, creating a physical copy does not integrate with the EHR system and is less efficient in fast-paced healthcare settings. Verbal communication, while important, relies on consistency and can lead to information being missed or misunderstood. Sending emails might not provide the immediate alertness required for urgent patient information, and it also risks important messages being overlooked in inboxes, rather than being integrated directly into the patient's electronic health record.

9. How can users archive old patient records in Epic?

- A. Through patient requests only
- B. Using designated report functions**
- C. By deleting records manually
- D. By contacting technical support

Users can archive old patient records in Epic using designated report functions, as these functions are specifically designed to facilitate the management of patient information, including the archiving process. The functionality allows users to filter, select, and summarize patient data that needs to be archived, thereby ensuring that the records are preserved effectively according to the healthcare organization's policies. The report functions typically provide a structured way to archive records, ensuring that necessary data is retained for compliance purposes, while also helping to maintain an efficient database by removing outdated or inactive records from active views. This method supports regular maintenance of the system and optimizes performance since archived records can be stored securely without cluttering the primary database. Other options do not align with best practices in data management within Epic. For example, relying solely on patient requests does not provide a systematic approach to archiving necessary records, while deleting records manually is generally not permitted due to regulatory requirements. Additionally, contacting technical support is unnecessary for routine archiving processes, which can be managed directly by users with appropriate access and training in Epic's reporting capabilities.

10. How can a nurse ensure effective communication regarding a documented goal?

- A. Share the documentation with team members**
- B. Keep the documentation confidential
- C. Limit discussions to immediate supervision
- D. Only distribute to physicians

To ensure effective communication regarding a documented goal, sharing the documentation with team members is essential. This practice fosters collaboration and ensures that everyone involved in patient care is on the same page regarding the objectives and strategies for the patient's treatment. When a nurse shares documented goals, it allows for a collective understanding among the care team, facilitating coordinated efforts to achieve those goals. Open communication enhances the likelihood of adherence to the care plan and allows team members to adjust their approaches based on a shared knowledge of the established objectives. Keeping the documentation confidential restricts necessary information flow that could aid in team coordination. Limiting discussions to immediate supervision would also undermine the collaborative efforts required in patient care, as it could lead to misunderstandings or gaps in knowledge about the patient's goals. Only distributing documentation to physicians can isolate critical information, preventing nursing staff and other allied health professionals from contributing effectively to patient care. By prioritizing the sharing of information with all relevant team members, a nurse not only promotes effective communication but also enhances patient safety and care quality.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://epicimp100.examzify.com>

We wish you the very best on your exam journey. You've got this!

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