

# EpicCare Inpatient Fundamentals (INP100) Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

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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. Which control should you click to add an NG tube to the flowsheet?**
  - A. Add Group**
  - B. Add Row**
  - C. LDA Avatar**
  - D. Add Column**
  
- 2. How do values appear prior to filing them to a patient's chart?**
  - A. In italics**
  - B. In bold**
  - C. With a shaded edge in their cell**
  - D. With a blue border**
  
- 3. Which action would be inappropriate when correcting the documented time of an assessment?**
  - A. Insert Col to set the actual time**
  - B. Leave the current time as the documented time**
  - C. Create a separate 7:15 column**
  - D. Add a separate 7:15 column**
  
- 4. What will you see if a medication has not been verified by pharmacy?**
  - A. Warnings indicating not verified, but administration can proceed.**
  - B. System lock.**
  - C. An error message requiring cancellation.**
  - D. No indication.**
  
- 5. Which statement best describes cosigning in Epic?**
  - A. The cosigning user attests but is not the author**
  - B. The cosigning user becomes the author**
  - C. The cosigning user has no role**
  - D. The author is always the nurse**

- 6. What is the purpose of a wildcard in the note entry?**
- A. Provide a place for free text.**
  - B. Store patient demographic data.**
  - C. Auto-fill prescription forms.**
  - D. Link to external systems.**
- 7. When adding a new hospital problem to the problem list, which control marks it as principal?**
- A. Pushpin icon**
  - B. Principal checkbox**
  - C. Add a comment**
  - D. Diamond**
- 8. What action by a nurse is described in Release Orders activity?**
- A. A nurse selects individual orders and clicks Release**
  - B. The nurse must release all orders at once**
  - C. The nurse cannot release orders**
  - D. Release occurs automatically at transfer**
- 9. How do you remove yourself from a patient's treatment team?**
- A. Remove yourself in the department's settings.**
  - B. End My Assignment from the patient's chart.**
  - C. Right-click the patient's row in the My Patients list and select End My Assignment.**
  - D. Delete the patient from your list.**
- 10. Can System Lists be added to your My Lists?**
- A. Yes**
  - B. No**
  - C. Only with admin**
  - D. Not applicable**

## Answers

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

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## **Explanations**

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**1. Which control should you click to add an NG tube to the flowsheet?**

- A. Add Group**
- B. Add Row**
- C. LDA Avatar**
- D. Add Column**

When adding a device or data item like an NG tube to a flowsheet, you use the control that opens the Linked Data Access (LDA) library and lets you insert standard lines into the chart. The LDA Avatar is that access point. It lets you pull in predefined data elements (such as an NG tube) and place them on the patient's flowsheet, which is exactly what you need for this task. Adding a row or a column would change the grid layout rather than insert the actual device data, and adding a group would organize items without embedding the NG tube entry itself. So the LDA Avatar is the correct path because it directly adds the NG tube data line from the library into the flowsheet.

**2. How do values appear prior to filing them to a patient's chart?**

- A. In italics**
- B. In bold**
- C. With a shaded edge in their cell**
- D. With a blue border**

The main idea is recognizing how Epic marks data that hasn't yet become part of the official chart. When you enter values that aren't filed, they appear with a shaded edge around their cell. This visual cue shows the data is in draft or pending status and not yet part of the permanent patient record. You can review or modify these values before you file them; once they're filed, the shading typically disappears and the data becomes a formal part of the chart. Other visual formats like italics, bold, or blue borders aren't standard indicators for this draft status.

**3. Which action would be inappropriate when correcting the documented time of an assessment?**

- A. Insert Col to set the actual time**
- B. Leave the current time as the documented time**
- C. Create a separate 7:15 column**
- D. Add a separate 7:15 column**

Accurate documentation requires keeping the original entry intact and recording the correction in a verifiable way. If you know the assessment time is wrong, leaving the documented time as-is would produce an inaccurate chart and undermine the record's integrity. The proper approach is to capture the actual time without erasing the original entry—such as inserting a column for the true time or adding a separate 7:15 entry—so both the original time and the corrected time are visible and auditable. This preserves a clear trail of what happened and when, which is essential for patient safety and legal accountability.

**4. What will you see if a medication has not been verified by pharmacy?**

- A. Warnings indicating not verified, but administration can proceed.**
- B. System lock.**
- C. An error message requiring cancellation.**
- D. No indication.**

When a medication hasn't been verified by pharmacy, the system typically displays a warning or alert indicating that verification is pending. This informs the clinician that while the medication can still be administered, its status isn't fully validated yet, so extra caution is taken with dosing, interactions, and appropriateness. The goal is to keep care timely while making sure the team is aware of the verification gap. System locks would prevent administration, which isn't standard for an unverified medication. An error message requiring cancellation is too strict for most workflows, since care may proceed with the caveat of the pending verification. No indication would fail to alert the clinician to the pending status, which isn't consistent with safe prescribing practices.

**5. Which statement best describes cosigning in Epic?**

- A. The cosigning user attests but is not the author**
- B. The cosigning user becomes the author**
- C. The cosigning user has no role**
- D. The author is always the nurse**

In Epic, cosigning means a second clinician reviews and attests to the accuracy and completeness of a chart entry or order, without taking over authorship. The cosigner signs to verify the content, but the original author remains responsible for what was documented. This distinction is why the statement that the cosigning user attests but is not the author is correct. The cosigner's role is to confirm and validate, not to rewrite or claim credit as the author. For example, a supervising physician may cosign a resident's progress note to attest that it reflects the patient's care, while the resident remains the author. The other options don't fit because cosigning does involve an attestation role, it does not transfer authorship, and the author isn't restricted to nurses—authors can be physicians, nurse practitioners, physician assistants, or other clinicians depending on the workflow.

**6. What is the purpose of a wildcard in the note entry?**

- A. Provide a place for free text.**
- B. Store patient demographic data.**
- C. Auto-fill prescription forms.**
- D. Link to external systems.**

Wildcards in note entry create a flexible space for free-text input, allowing clinicians to add narrative details that aren't captured by fixed fields. This is essential because patient stories, nuanced observations, changes in condition, or reasoning often don't fit neatly into predefined templates. The wildcard acts as a placeholder where you can type exactly what matters in that moment, making the note more complete and clinically useful. This isn't about storing demographics, which live in dedicated patient-data fields; it isn't about automatically filling prescription forms, which relies on medication templates and order logic; and it isn't about linking to external systems, which requires interoperability interfaces. The wildcard's purpose is simply to give you a space to record free-text information.

**7. When adding a new hospital problem to the problem list, which control marks it as principal?**

- A. Pushpin icon**
- B. Principal checkbox**
- C. Add a comment**
- D. Diamond**

Flagging the primary problem uses a dedicated Principal checkbox. This binary control is specifically designed to mark which problem in the list is the main one for the current encounter. Checking it designates that problem as the principal, guiding how it's displayed, prioritized, and used in documentation and care planning. Other interface elements like a pushpin, adding a comment, or a diamond are for different actions (quick access, notes, or visual status) and do not establish which problem is the principal. So, selecting the Principal checkbox is the correct way to designate the main problem.

**8. What action by a nurse is described in Release Orders activity?**

- A. A nurse selects individual orders and clicks Release**
- B. The nurse must release all orders at once**
- C. The nurse cannot release orders**
- D. Release occurs automatically at transfer**

Release Orders tests the step where a nurse makes specific orders active in the patient's chart. The best way to do this is for the nurse to review pending or held orders, select individual orders that should go into effect, and click Release on each one. This granular action lets the nurse activate only the intended orders at the correct time, which is essential for patient safety and accurate workflow. Releasing all orders at once would take away this level of control and could activate unwanted orders. The function is designed for selective activation by the nurse, not for automatic or bulk release, and it requires deliberate nurse involvement to confirm each order.

**9. How do you remove yourself from a patient's treatment team?**

- A. Remove yourself in the department's settings.**
- B. End My Assignment from the patient's chart.**
- C. Right-click the patient's row in the My Patients list and select End My Assignment.**
- D. Delete the patient from your list.**

Removing yourself from a patient's treatment team is done directly in your My Patients list. You locate the patient's row, right-click it, and choose End My Assignment. This specifically removes your active role on that patient's care, updating your treatment-team view without affecting other users or the patient's chart. It's the intended workflow for stepping back from a patient. Other options don't fit because changing department-wide settings affects everyone, ending the assignment from the chart isn't the per-user workflow for disengaging from a patient, and deleting the patient from your list would either not remove you from the team or could disrupt records.

**10. Can System Lists be added to your My Lists?**

- A. Yes**
- B. No**
- C. Only with admin**
- D. Not applicable**

You can add System Lists to your My Lists, which lets you bring standard, system-provided lists into your personal workspace for quick access and consistent filtering. System Lists are built-in resources that many users rely on, and adding one to My Lists keeps the familiar, predefined criteria handy while you customize your own workflow. No special admin rights are needed; this is a standard capability. For example, you might add a System List like "Active Patients by Ward" to your My Lists so you can open it with a single click whenever you're on rounds.

## 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](mailto:hello@examzify.com).**

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

**<https://epiccareinpatientfund.examzify.com>**

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

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