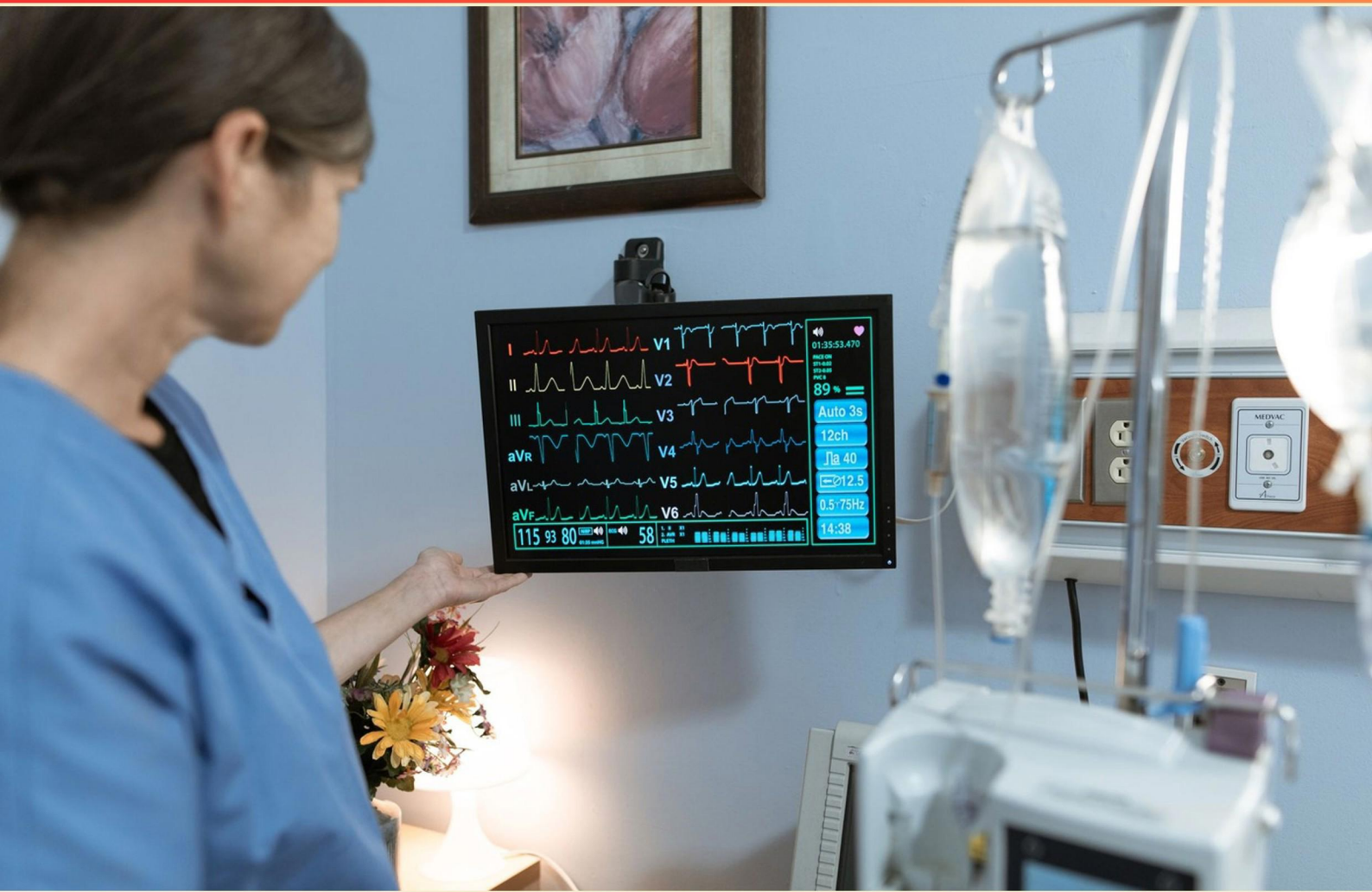


EPIC CARE INPATIENT FUNDAMENTALS (INP100) PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://epiccareinpatientfund.examzify.com>



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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. During discharge, which should be done first and why?**
 - A. End the discharge process
 - B. Write new outpatient orders first, because they may need to be linked to an active problem
 - C. Resolve all problems before prescribing medications
 - D. Reconcile medications
- 2. In the Admit Orders process, which tool is used to insert free text when information is missing?**
 - A. Wildcard
 - B. SmartLink
 - C. SmartList
 - D. Flowsheet
- 3. To ensure the assessment uses the current date and time, which action should you perform?**
 - A. Add Col button
 - B. Now hyperlink
 - C. Insert Col
 - D. Add Row
- 4. What are alarms and alerts in Epic INP100 and how should they be managed?**
 - A. User-created reminders for noncritical tasks with no policy requirement.
 - B. Automatic billing prompts unrelated to clinical care.
 - C. System-generated notifications for critical events; they should be acknowledged and addressed promptly per policy.
 - D. Reports generated monthly for safety reviews only.
- 5. Which choice enables you to add a time-specific column to a flowsheet?**
 - A. Add Col
 - B. Insert Col
 - C. Compact
 - D. Hide Comp'd

- 6. What happens when you type 'help' in the Add Prior to Admission Med search field?**
- A. Adds the Unknown to Patient to the med list.
 - B. The search field clears.
 - C. Searches for drug name.
 - D. Searches for 'help' topics.
- 7. How do you document allergies and sensitivities in Epic INP100?**
- A. In the MAR with dosage information.
 - B. In the Allergies section of the chart, record the allergen, reaction, and severity to trigger alerts.
 - C. In the Imaging Results viewer.
 - D. In the Billing module under insurance.
- 8. What does the acronym WDL stand for in defined limits on the flowsheet?**
- A. With Defined Limits
 - B. Within Defined Limits
 - C. Wide Defined Limits
 - D. Within Data Limits
- 9. Where would you view a patient's active problems in the chart?**
- A. Diagnosis section only.
 - B. Medications section.
 - C. Problem List or Diagnosis section.
 - D. Billing history.
- 10. Private reports can be shared with other individuals by the creator.**
- A. False
 - B. Only with manager approval
 - C. Only during a project phase
 - D. True

Answers

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

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Explanations

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1. During discharge, which should be done first and why?

- A. End the discharge process
- B. Write new outpatient orders first, because they may need to be linked to an active problem**
- C. Resolve all problems before prescribing medications
- D. Reconcile medications

During discharge, the first step is to write new outpatient orders, especially because they may need to be linked to the active problem. Placing these orders upfront ensures the outpatient plan directly corresponds to the issue currently active in the patient's chart, which preserves continuity of care and makes the handoff to the outpatient team clear. If you end the discharge process before these orders are in place, the plan may lose its context and important follow-up actions could be missed. Medication reconciliation and resolving problems are essential parts of discharge, but they come after establishing the outpatient orders that tie tightly to the active problem. Starting with the outpatient orders creates a coherent bridge from inpatient care to the outpatient setting, and then you can finalize meds and the overall plan with the correct linkage in place.

2. In the Admit Orders process, which tool is used to insert free text when information is missing?

- A. Wildcard**
- B. SmartLink
- C. SmartList
- D. Flowsheet

When information is missing in an Admit Order, you use a wildcard. A wildcard acts as a placeholder that lets you enter free text directly into the order, so you can document the missing details or notes even when there isn't a predefined value to select. This keeps the workflow moving and preserves the clinician's intent for the order. SmartLink is for inserting standardized blocks of text or data linked to the patient, SmartList offers a curated set of predefined options to choose from, and Flowsheet is a grid view for recording and reviewing patient data over time. None of these are the placeholder tool used to capture free-text notes in an Admit Order.

3. To ensure the assessment uses the current date and time, which action should you perform?

- A. Add Col button
- B. Now hyperlink**
- C. Insert Col
- D. Add Row

The concept is using a dynamic timestamp so the assessment reflects the current date and time, not a fixed, static value. In Epic forms, inserting the Now hyperlink provides a live date/time field that automatically pulls from the system clock, ensuring the timestamp updates to the moment the assessment is opened or saved. The other options change the table layout (adding columns or rows) and do not insert or update a date/time value, so they won't guarantee the assessment uses the current moment.

4. What are alarms and alerts in Epic INP100 and how should they be managed?

- A. User-created reminders for noncritical tasks with no policy requirement.
- B. Automatic billing prompts unrelated to clinical care.
- C. System-generated notifications for critical events; they should be acknowledged and addressed promptly per policy.**
- D. Reports generated monthly for safety reviews only.

Alarms and alerts in Epic INP100 are system-generated notifications that flag critical events requiring immediate attention. They're designed to surface urgent clinical information to the right care team, and staff should acknowledge them and take action promptly according to facility policy and escalation procedures. This isn't about user-created reminders for noncritical tasks, billing prompts, or monthly safety reports. Proper management means acknowledging within the specified time, following the defined workflow to address the issue, documenting actions taken, and escalating if needed to ensure patient safety.

5. Which choice enables you to add a time-specific column to a flowsheet?

- A. Add Col
- B. Insert Col**
- C. Compact
- D. Hide Comp'd

When you need to place data for a specific time in a flowsheet, you must create a new column in the exact position where that time appears. The Insert Col action does exactly that: it adds a new column in the chosen spot so you can label it with the desired time (or interval) and enter data for that moment. This is essential for maintaining a clear, chronological record across the flowsheet. Adding a column typically appends it to the end, which may disrupt the intended time sequence. Compact is about tightening the layout or reducing space, and Hide Comp'd hides computed columns; neither of these creates a new time-specific column in a specific position. So inserting a column is the correct method to place a time-specific column where you want it.

6. What happens when you type 'help' in the Add Prior to Admission Med search field?

- A. Adds the Unknown to Patient to the med list.**
- B. The search field clears.
- C. Searches for drug name.
- D. Searches for 'help' topics.

In this field, typing a non-specific term like "help" acts as a placeholder action to support med reconciliation when the exact medication isn't known. The system automatically adds an entry labeled Unknown to Patient to the medication list, signaling that there is a med to record but its identity is unknown. This helps ensure the patient's med history isn't left incomplete and can be updated later as more information becomes available. It isn't simply clearing the field, searching for a drug name, or pulling up help topics—the field is designed to add a placeholder entry when the exact medication can't be identified.

7. How do you document allergies and sensitivities in Epic INP100?

- A. In the MAR with dosage information.
- B. In the Allergies section of the chart, record the allergen, reaction, and severity to trigger alerts.**
- C. In the Imaging Results viewer.
- D. In the Billing module under insurance.

Allergies and sensitivities are recorded in the Allergies section of the patient's chart, where you enter the allergen, the reaction, and the severity so the system can trigger alerts and decision support. This placement ensures that the allergy information is available at the point of care across orders and documentation, so when a clinician writes a med or orders a test, Epic automatically checks for potential drug-allergy interactions and flags important safety considerations. Documenting details like the exact allergen, what happened, and how severe it was helps determine what actions are needed—such as avoiding certain meds, choosing alternatives, or requiring physician review. The other options don't fit because the MAR is used for recording medication administration details, not for documenting allergies; the Imaging Results viewer is for viewing imaging findings; and the Billing module under insurance handles financial and payer information, not clinical allergy data.

8. What does the acronym WDL stand for in defined limits on the flowsheet?

- A. With Defined Limits
- B. Within Defined Limits**
- C. Wide Defined Limits
- D. Within Data Limits

On a flowsheet, defined limits are the preset acceptable ranges for measurements. WDL is the shorthand used to indicate that a value falls within those boundaries. Therefore, WDL stands for Within Defined Limits. This labeling lets clinicians scan quickly to see which values are normal and which are out of range; when a value is outside the limits, it's typically flagged differently to draw attention. The other phrases don't align with the standard terminology used on flowsheets, either by changing the meaning or using nonstandard wording.

9. Where would you view a patient's active problems in the chart?

- A. Diagnosis section only.
- B. Medications section.
- C. Problem List or Diagnosis section.**
- D. Billing history.

Active problems are tracked in the Problem List. This list is the centralized place in an inpatient chart for current issues that require management, with statuses like Active or Resolved, and it guides care planning, orders, and monitoring. The Diagnosis section may show identified conditions, but it's primarily used for coding and billing, not as the ongoing view of what's actively affecting the patient. Medications and billing history do not represent the patient's active problems.

10. Private reports can be shared with other individuals by the creator.

- A. False
- B. Only with manager approval
- C. Only during a project phase

D. True

Allowing the creator to share a private report reflects how access controls work: the owner can grant access to others as needed, provided those users have the appropriate role or permissions. In EpicCare INP, this means the person who created the report can authorize others to view or collaborate on it, so the statement is true. This sharing isn't inherently limited to manager approval or restricted to a project phase; permissions and role-based access govern who can see the report and when. Of course, always consider privacy rules and patient information protections when sharing any private data.

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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://epiccareinpatientfund.examzify.com>

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

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