Mini RCA High Inpatient INR Process Improvement Discovery Tool (Minimum 10 charts/Maximum 20 charts) **Note: Do NOT spend more than 20-30 minutes per chart!**

Instructions: (1) Mark an X in the box where a process failure occurred. You may check more than one box per chart. (2) The processes with the most common failures could be a priority focus.

Process	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:
The prescriber was managing the warfarin without pharmacy assistance.																				
An INR was not obtained and resulted before the first inpatient dose was ordered.																				
Daily INRs were not obtained.																				
Dosage adjustments were not made based on the last daily INR result.																				
Dosage adjustments were reactive ("oops, too high"), not anticipatory ("it's going up fast, time to decrease the dose").																				
Warfarin dosage adjustments were made based upon known drug-drug interactions.																				
Warfarin dosage adjustments were made based upon known food-drug interactions.																				
Patient history of poor INR control predicted that this patient would create challenges for warfarin management.																				
At least one inpatient warfarin dose was missed or refused.																				
Warfarin or other medication errors (e.g. wrong med, wrong, dose, missed dose) occurred that would affect the INR.																				
Other (specify)																				