Freestanding Emergency Room Medical Director Chart Review & Quality Review Resource

A practical framework for physician chart review, patient safety, OPPE, peer review and QAPI

For freestanding emergency rooms, Medical Directors, quality committees and medical staff leadership. Texas regulatory focus. Reference review: September 9, 2026.

Overview

Routine physician chart review should be more than a documentation audit.

For a freestanding emergency room, effective chart review should determine whether the patient received **safe, clinically appropriate and timely emergency care**, whether the medical record accurately reflects that care, and whether individual cases reveal opportunities to improve the physician, the clinical team or the healthcare system.

A strong Medical Director review asks a simple sequence of questions:

Was the patient appropriately evaluated? → Were dangerous diagnoses considered? → Was testing appropriate? → Was treatment appropriate? → Was the patient reassessed? → Was the disposition safe? → Was the patient appropriately informed? → What can the organization learn from the encounter?

This resource combines publicly available principles and standards from **The Joint Commission, Mayo Clinic and Cleveland Clinic** with the regulatory responsibilities applicable to Texas freestanding emergency medical care facilities.

It is intended as a **guidance and quality-improvement resource**, not as a proprietary Cleveland Clinic, Mayo Clinic or Joint Commission chart-review instrument.

Why Medical Director Chart Review Matters in a Freestanding ER

Emergency medicine requires physicians to make high-risk decisions using incomplete information and often under significant time pressure. A retrospective chart review provides an opportunity to evaluate the entire patient journey after the immediate clinical pressures have passed.

For Texas freestanding emergency medical care facilities, medical staff oversight is not merely administrative. Current 26 TAC §509.45 requires the medical staff to periodically conduct appraisals of its members according to the medical staff bylaws and makes the medical staff accountable to the governing body for the quality of medical care provided to patients. [4]

Texas Health and Safety Code Chapter 254 establishes the statutory framework for freestanding emergency medical care facilities, while 26 TAC Chapter 509 contains the facility licensing and operational requirements. [1, 2]

A Note About Joint Commission Standards

Beginning **January 1, 2026**, Joint Commission replaced the former Hospital National Patient Safety Goals chapter with its **National Performance Goals, or NPGs**. The 14 NPG topics organize existing requirements around major patient-safety and quality priorities. [11]

Joint Commission currently publishes these NPGs for its **Hospital and Critical Access Hospital accreditation programs**. Therefore, an independently licensed freestanding ER should determine which Joint Commission standards formally apply based upon its accreditation status and organizational structure.

Nevertheless, these standards provide a useful high-reliability framework for emergency-care quality review.

Joint Commission also specifically recognizes periodic chart review as a possible source of information in **Ongoing Professional Practice Evaluation (OPPE)**. Examples include evaluation of documentation quality and accuracy, appropriateness of tests and procedures, and patient outcomes. [13]

Its FPPE guidance further states that professional-practice evaluation applies to practitioners providing medical-level care or decision-making and may include freestanding emergency or urgent-care centers that fall within the surveyed organization's scope. [14]

The Medical Director's Chart Review Model

A practical FSER chart review can be organized into seven core domains.

Domain	Primary Question
Initial Assessment	Was the patient's condition appropriately recognized at presentation?
History & Examination	Was enough relevant clinical information obtained to understand the problem?
Medical Decision-Making	Were serious diagnoses considered and clinical decisions reasonable?
Testing & Treatment	Were diagnostic studies and treatments appropriate?
Reassessment	Did the physician evaluate the patient's response and changing condition?
Disposition	Was discharge, observation or transfer safe and appropriate?
Documentation & Communication	Does the medical record accurately tell the patient's clinical story?

1. Initial Assessment

The chart should establish the clinical condition of the patient when the encounter began.

Medical Director review should assess whether the record demonstrates:

Patient identification • Chief complaint • Initial vital signs • Acuity • Allergies • Relevant medications • Pain when applicable • Medical screening examination • Immediate threats to life or function

Joint Commission's **NPG #1 — Right Patient, Right Care** emphasizes reliable patient identification, timely critical-result communication, effective handoffs, patient-flow management, recognition of changes in condition and availability of resuscitative care. [11]

Medical Director Question

Could another emergency physician reading this record understand how sick the patient appeared when they arrived?

2. History and Physical Examination

The goal is not simply documentation volume.

The record should contain the **relevant information necessary to evaluate and treat the patient's actual presenting condition**.

Joint Commission states that required H&P content should be relevant and contain sufficient information to address the patient's condition, planned care and assessed needs. The specific content may appropriately vary according to the services provided and patient population. [15]

The reviewer should evaluate the adequacy of the HPI, pertinent positives and negatives, significant comorbidities, medications, allergies, risk factors and focused physical examination.

Medical Director Question

Does the history and examination provide enough clinical evidence to support the decisions that follow?

3. Medical Decision-Making and Diagnostic Safety

Give medical decision-making particular clinical attention. The companion form weights all scored rows equally; serious findings override the total score.

A chart may be technically complete but still demonstrate weak medical decision-making.

The Medical Director should determine whether:

The differential diagnosis was reasonable. Potentially dangerous diagnoses were considered. The diagnostic strategy matched the clinical risk. Important abnormal results were addressed. The physician's final diagnosis and disposition logically followed from the available information.

For common high-risk emergency presentations, reviewers should specifically consider whether dangerous alternative diagnoses were appropriately evaluated.

Presentation	Examples of High-Risk Diagnoses to Consider
Chest pain	ACS, PE, aortic catastrophe
Dyspnea	PE, ACS, CHF, pneumonia, pneumothorax
Neurological deficit	Stroke, TIA, intracranial hemorrhage
Syncope	Cardiac arrhythmia, structural cardiac disease, hemorrhage
Abdominal pain	Surgical abdomen, AAA, ectopic pregnancy
Headache	Intracranial hemorrhage, meningitis, mass lesion
Fever	Sepsis, serious bacterial infection
Trauma	Intracranial, thoracic, abdominal or vascular injury

The purpose is not to require exhaustive testing for every possible diagnosis. The purpose is to determine whether the physician **recognized important clinical risk and made a reasonable decision based upon that risk**.

4. Diagnostic Testing, Imaging and Treatment

The reviewer should evaluate both underuse and unnecessary utilization.

Ask whether laboratory testing, CT, X-ray, ultrasound, ECG and other diagnostic studies were clinically justified and whether the results were available, interpreted and acted upon before disposition when appropriate.

Joint Commission's 2026 performance framework includes specific goals addressing safe imaging, medication management and correct-care processes. [12]

Medication review should address indication, allergy status, dose, route, relevant contraindications, high-risk medications and response to therapy.

Joint Commission's **NPG #14 — Effectively Managing Medications** emphasizes safe medication processes, accurate medication information, anticoagulant safety, medication storage/dispensing and antimicrobial stewardship. [11]

Medical Director Question

Did every important test or treatment have a reasonable clinical purpose, and did the physician appropriately respond to the results?

5. Reassessment: The Frequently Missed Safety Step

An emergency encounter is a changing clinical process.

A patient's initial condition does not necessarily determine whether discharge is appropriate several hours later.

The reviewer should look for evidence of:

Repeat vital signs when indicated • Pain reassessment • Clinical response to medication or IV treatment • Repeat neurological/respiratory/cardiovascular examination when indicated • Recognition of deterioration • Final clinical condition

Joint Commission's Right Patient, Right Care framework specifically emphasizes recognizing and responding to changes in a patient's condition. [11]

Important Medical Director Question

Was this patient demonstrably safe for the disposition chosen at the end of the encounter?

Unexplained significant abnormalities in heart rate, blood pressure, respiratory rate, oxygen saturation, temperature, mental status or uncontrolled pain deserve particular attention during chart review.

6. Discharge, Observation and Transfer

Discharge Review

The discharge portion of the record should show that the patient was clinically appropriate for outpatient care.

Review should include the final diagnosis, clinical stability, medication instructions, follow-up plan, pending results, referrals and condition-specific return precautions.

Joint Commission's **NPG #7 — Safe Informed Care** emphasizes communication patients can understand, patient involvement in care, dignity, informed decision-making and appropriate patient protections. [11]

A discharge instruction stating only **"return if worse"** should generally not substitute for clinically meaningful return precautions when more specific instructions can reasonably be provided.

Observation Review

When observation services are used, the record should demonstrate why observation was medically appropriate, what clinical endpoint was being monitored, what reassessments occurred and why the ultimate disposition was appropriate.

Transfer Review

Transfer cases deserve focused Medical Director scrutiny because they involve both clinical and operational risk.

Review should determine whether:

The need for transfer was recognized promptly. The patient was treated and stabilized within the FSER's capability. Receiving-facility acceptance was documented. Appropriate transportation was arranged. The patient was monitored while awaiting transfer. Significant changes were addressed. Pertinent records and results accompanied or were communicated to the receiving team.

Texas FSER licensing rules specifically address patient-transfer policies and agreements. The licensing provisions require facilities to maintain a transfer policy for patients needing care beyond the facility's capabilities and a written agreement addressing prompt transfer and admission. [7]

7. Behavioral Health and Suicide Safety

When the emergency encounter involves behavioral-health conditions or suicidal ideation, chart review should include suicide screening, subsequent assessment when indicated, level-of-risk documentation, precautions, monitoring, disposition planning and follow-up.

Joint Commission's **NPG #8 — Reducing the Risk for Suicide** requires hospitals within its applicable accreditation programs to use validated screening for patients being treated primarily for behavioral-health conditions, perform evidence-based assessment when screening is positive, document risk and mitigation plans, and address counseling and follow-up at discharge. [11]

Documentation Quality: Does the Chart Tell the Clinical Story?

Documentation should enable another qualified physician to reconstruct what happened.

The Medical Director should look for internal consistency among the history, examination, orders, nursing documentation, results, reassessments, MDM and disposition.

The record should particularly demonstrate:

What the physician believed was happening. What dangerous conditions were considered. Why tests were or were not obtained. How abnormal results were interpreted. How the patient responded to treatment. Why discharge, observation or transfer was appropriate.

Joint Commission's medical-record guidance recognizes organizational responsibility for timely authentication and medical-record completion, subject to applicable law, regulations, facility policy and medical-staff requirements. [16]

Recommended Chart Review Scoring

For a standardized internal Medical Director tool, a simple scoring system works well:

2 — Meets Standard

Care/documentation is clinically appropriate and clearly supported.

1 — Partially Meets Standard

Care is generally appropriate, but documentation, reasoning, timeliness or follow-through could be improved.

0 — Does Not Meet Standard

Important omission, deviation, questionable care or significant documentation deficiency.

N/A — Not Applicable

A facility may adopt internal performance categories such as **Excellent, Meets Expectations, Improvement Recommended and Medical Director Follow-Up Required**.

These numerical thresholds should be identified as **facility-defined QAPI benchmarks**, not Joint Commission scoring requirements.

Serious Findings Override the Score

A physician should not automatically receive a satisfactory quality determination simply because the numerical score is high.

Certain findings should trigger individual review regardless of the aggregate score, particularly:

Unexpected death • Significant missed or delayed diagnosis • STEMI or stroke concern • Sepsis recognition/treatment concern • Serious medication error • Unexpected deterioration • Significant procedure complication • Unaddressed critical result • Unexplained unstable discharge vital signs • Significant transfer delay • 72-hour return resulting in admission/transfer • Serious patient complaint • Possible EMTALA/MSE concern • Repeated documentation or clinical-performance concerns

These cases may be appropriate for additional chart review, peer review, OPPE trending, FPPE or formal quality review depending upon the circumstances.

Connecting Chart Review to OPPE and FPPE

A chart-review program becomes substantially more useful when individual findings are aggregated into physician-performance information.

Joint Commission describes OPPE as an ongoing process using information relevant to practitioner performance. Its examples of qualitative data specifically include periodic chart reviews evaluating documentation quality, appropriateness of testing/procedures and patient outcomes. [13]

When a specific concern arises about a currently privileged practitioner's ability to provide safe, high-quality care, Joint Commission describes **Focused Professional Practice Evaluation (FPPE)** as a mechanism for evaluating that concern. FPPE also applies to newly requested privileges within applicable accredited organizations. [14]

A practical sequence is:

Routine Chart Review → Trend Identification → OPPE → Education/Improvement → Additional Sampling → FPPE when warranted → Formal Peer Review when appropriate

The exact peer-review and credentialing process should follow the facility's bylaws, policies, state requirements and applicable accreditation standards.

From Chart Review to QAPI

The real value of chart review appears when repeated findings become measurable improvement work.

A Medical Director should ask:

Is this an isolated physician issue? Is this a facility-system issue? Is it both?

For example, repeated delayed transfers may initially appear to be physician performance problems but could reveal an inadequate transfer-center process.

Repeated failure to document critical laboratory follow-up may reveal an EHR workflow deficiency.

Repeated discharge-instruction problems could indicate a standardized template problem rather than an individual physician problem.

Cleveland Clinic's publicly described patient-safety model emphasizes a **just culture**, reporting of safety opportunities, system improvement, leadership engagement, EMR-supported communication and organizational learning rather than simply assigning individual blame. [19]

This is an important principle for FSER Medical Directors:

Correct the practitioner when the practitioner is the problem. Correct the system when the system is the problem. Correct both when both contribute.

Incorporating the Mayo Clinic Quality Model

Mayo Clinic's publicly described approach provides another useful framework for FSER quality programs.

Mayo describes quality using multiple dimensions, including **patient outcomes, evidence-based clinical processes, patient experience and safety**. It also emphasizes continuous improvement rather than reliance upon a single quality measure. [17, 18]

That model translates well to FSER chart review.

A Medical Director dashboard should therefore not contain only a documentation score.

It should eventually combine:

Clinical Outcomes + Process Compliance + Patient Safety + Patient Experience + Physician Performance + Operational Performance

Monthly Medical Director Review Program

For most freestanding emergency facilities, a sustainable program is more valuable than an overly complicated audit process.

A practical monthly review process can include representative physician chart sampling plus targeted review of high-risk cases.

Sampling should intentionally include different physicians, shifts, presenting complaints, acuity levels and dispositions.

High-risk encounters should be added to the random sample rather than relying exclusively on random chart selection.

The facility should define its sampling methodology in Medical Staff/QAPI policy rather than presenting a particular sample size as a Joint Commission requirement.

Suggested Medical Director Dashboard

Quality domain	Suggested measures
Physician quality	Chart-review scores; diagnostic reasoning and documentation concerns
Patient safety	Adverse events, medication errors, diagnostic concerns and deaths
Returns	72-hour returns and returns requiring transfer or admission
Transfers	Transfer volume, delay reasons and decision-to-departure interval
Clinical pathways	STEMI, stroke, sepsis and other facility-approved pathway measures
Reassessment	Repeat vital signs and response-to-treatment documentation
Patient experience	Clinical complaints, communication and discharge understanding
Improvement follow-through	Action completion, remeasurement and sustained improvement

Define each measure, its numerator and denominator, data source, owner, review interval and target before comparing results. Display the number of charts reviewed and the sampling method alongside scores. Targeted high-risk reviews should be distinguishable from representative samples.

Texas Regulatory Responsibilities

The Medical Director has explicit infection-control and QAPI oversight duties and must be on-site at least 12 hours per month under Section 509.44. Medical staff member appraisal follows the bylaws under Section 509.45. [3, 4]

Section 509.63 requires an ongoing, facility-wide, data-driven, interdisciplinary QAPI program. Meetings must be documented and held monthly, or more often as needed. Monthly tracking includes infection control, adverse events, mortality, complaints and suggestions, staffing, safety and clinical record review, including treatment and medication errors. Review each death; immediately correct identified threats to patient health and safety. Chart sampling supports this program but does not replace its broader requirements. [6]

Texas medical record entries must be legible, accurate, complete, dated, timed and authenticated no later than 48 hours after discharge. Transfer policies and agreements must meet Sections 509.65 and 509.66; medical staff must review appropriate transfer records. Include receiving acceptance, transport needs, relevant records, the transfer memorandum and required consent or certification in the transfer review. [5, 7, 8]

Federal EMTALA and State Screening Duties

Federal EMTALA obligations depend on Medicare-participating hospital status and the applicable hospital emergency-department framework, including qualifying off-campus departments. Do not infer federal applicability solely from the freestanding ER name. Independently, Texas Health and Safety Code Section 254.153 requires licensed facilities to provide appropriate screening, examination and stabilizing care within their capability without regard to ability to pay. [1, 10]

Using the Two Page Working Form

Use one form per encounter. Complete the identification fields, score each applicable item and explain deficiencies on Page 2. For grouped criteria, apply the facility-approved rubric consistently and identify which component did not meet the standard. N/A means the element did not apply; missing required evidence is not N/A.

The form contains 35 scored rows. Maximum applicable points = 2 × (35 minus N/A rows). Score = points earned ÷ maximum applicable points × 100. If no items apply, record “not scorable.” Example: 3 N/A rows leave 64 possible points; 58 points earns 90.6%.

Suggested internal categories are 95–100% Excellent; 90–<95% Meets Expectations; 80–<90% Improvement Recommended; and <80% Medical Director Follow-Up Required. These are facility-defined benchmarks, not Joint Commission thresholds or a validated measure of physician competence. Do not round a result upward to change its category. Serious safety findings require review regardless of score.

Page 2 records the clinical determination, quality triggers, primary findings, peer-review disposition, QAPI action, owner, due date, remeasurement and signature. Escalate urgent concerns promptly; do not wait for the monthly meeting. Handle completed forms through approved confidential quality and peer-review processes. A form label alone does not establish legal privilege.

Closing the Improvement Loop

Document the concern and supporting evidence, assign an accountable owner, set an achievable completion date and define how improvement will be measured. Record the follow-up finding and whether the action resolved the concern. Use additional sampling, OPPE trending, focused evaluation or formal peer review as appropriate under the facility’s bylaws and policies. Clinical review should consider the information available at the time of care and distinguish practitioner decisions from system contributors. [6, 13, 14, 19]

Regulatory and Reference Library

The numbered entries below support the article and companion form. Links lead to source texts or authoritative publication pages; the library is not a reproduction of proprietary accreditation manuals. Sources reviewed September 9, 2026. Verify the applicable current law, accreditation program and facility policy when adopting or revising a review process.

Texas Statutes and Facility Rules

[1] **Texas Legislature. Health and Safety Code Chapter 254. Freestanding Emergency Medical Care Facilities.**

State statute. Section 254.153 covers screening and stabilizing care without regard to ability to pay and a hospital referral, transmission, or admission agreement.

https://statutes.capitol.texas.gov/Docs/HS/htm/HS.254.htm

[2] **Texas Administrative Code. Title 26 Part 1 Chapter 509. Freestanding Emergency Medical Care Facilities.**

State licensing rules. Linked text is the Cornell Legal Information Institute reproduction; confirm the current official text through Texas HHSC and the Secretary of State.

https://www.law.cornell.edu/regulations/texas/title-26/part-1/chapter-509

[3] **26 TAC Section 509.44. Medical Director.**

Medical Director presence, emergency service organization, infection control and QAPI oversight, and external peer review authority.

https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-509-44

[4] **26 TAC Section 509.45. Medical Staff.**

Periodic member appraisals under bylaws; medical staff accountability to the governing body and privileging responsibilities.

https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-509-45

[5] **26 TAC Section 509.54. Medical Records.**

Record content, confidentiality, retention, availability and authentication. Subsection (k) specifies completion and authentication no later than 48 hours after discharge.

https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-509-54

[6] **26 TAC Section 509.63. Quality Assessment and Performance Improvement.**

Facility-wide, interdisciplinary QAPI; documented monthly meetings, monthly indicator tracking, improvement plans and sustained follow-through.

https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-509-63

[7] **26 TAC Section 509.65. Patient Transfer Policy.**

Transfer evaluation, acceptance, transport, records and memorandum requirements. Subsection (b)(7) requires medical staff review of appropriate transfer records.

https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-509-65

[8] **26 TAC Section 509.66. Patient Transfer Agreements.**

Mandatory hospital transfer agreements, HHSC review and minimum agreement provisions.

https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-509-66

[9] **Texas HHSC. Form 6104. Freestanding Emergency Medical Care Facility Incident Report.**

Operational reporting resource. Use with Chapter 509 reporting requirements; internal peer review does not replace required reporting.

https://fhb.hhs.texas.gov/forms/6000-6999/form-6104-freestanding-emergency-medical-care-facility-incident-report

Federal Emergency Care Requirements

[10] **CMS. Emergency Medical Treatment and Labor Act.**

Federal overview and links to 42 CFR 489.24 and State Operations Manual Appendix V. Determine applicability from hospital participation and department status.

https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act

Accreditation Standards and Interpretation

[11] **Joint Commission. National Performance Goals. Effective January 1 2026.**

Hospital and Critical Access Hospital programs. Official landing page links the full chapters and briefs for Goals 1, 2, 6, 7, 8, 13 and 14 discussed in this resource.

https://www.jointcommission.org/en-us/standards/national-performance-goals

[12] **Joint Commission. 2026 Hospital National Performance Goals.**

Official summary of all 14 goal topics; use the applicable full standards for compliance decisions.

https://digitalassets.jointcommission.org/api/public/content/8d49c3ffa9934ffda2ff83b5ad860ea7?v=a144828f

[13] **Joint Commission. Ongoing Professional Practice Evaluation Understanding the Requirements. Updated January 7 2026.**

OPPE scope and qualitative and quantitative data, including periodic chart review, documentation, tests and patient outcomes.

https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001322

[14] **Joint Commission. Focused Professional Practice Evaluation Understanding the Requirements. Updated January 7 2026.**

New privileges and focused evaluation when competence concerns arise; includes settings within the hospital survey scope.

https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001115

[15] **Joint Commission. History and Physicals Understanding the Requirements. Updated January 7 2026.**

Relevant H&P content determined by the medical staff, service and population; applicable legal requirements and organizational policies remain controlling.

https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001169

[16] **Joint Commission. Hospital Crosswalk. Accreditation 360.**

Reference for medical record completeness, accuracy and authentication. Consult the current applicable accreditation manual.

https://digitalassets.jointcommission.org/api/public/content/e38b871503004dd4ae4b2b30cd77f554?v=c063d6d5

Public Quality and Patient Safety Models

[17] **Mayo Clinic. Quality and Mayo Clinic.**

Public quality framework covering outcomes, evidence-based processes, safety and the patient experience. Not an FSER regulatory standard.

https://www.mayoclinic.org/about-mayo-clinic/quality

[18] **Mayo Clinic. Quality Measures.**

Outcome and process measures, patient experience and continuous improvement. Informational model rather than an adopted FSER scoring instrument.

https://www.mayoclinic.org/about-mayo-clinic/quality/quality-measures.

[19] **Cleveland Clinic. Patient Safety Program.**

Just culture, safety reporting, system improvement, leadership involvement and coordinated information access.

https://my.clevelandclinic.org/departments/patient-experience/depts/quality-patient-safety/patient-safety-program

[20] **Cleveland Clinic. Emergency Medicine Care.**

Public description of emergency quality priorities, including stroke, heart attack and infection care; not a clinical pathway or regulatory mandate.

https://my.clevelandclinic.org/services/emergency-medicine-care

Abbreviations

AAA: abdominal aortic aneurysm; ACS: acute coronary syndrome; AMA: against medical advice; CHF: congestive heart failure; EMTALA: Emergency Medical Treatment and Labor Act; FPPE: Focused Professional Practice Evaluation; FSER: freestanding emergency room; H&P: history and physical; HPI: history of present illness; LWBS/LBTC: left without being seen / left before treatment complete; MDM: medical decision-making; MSE: medical screening examination; OPPE: Ongoing Professional Practice Evaluation; PE: pulmonary embolism; QAPI: Quality Assessment and Performance Improvement; STEMI: ST-elevation myocardial infarction; TIA: transient ischemic attack.