Freestanding Emergency Room Nursing Director Chart Review Guidance

Guidance for monthly nursing quality review and use of the companion encounter checklist. For Nursing Directors, nurse managers, clinical educators and quality teams. Prepared September 11, 2026.

Purpose and Source Boundaries

Review whether nursing assessment, interventions, surveillance, escalation and communication supported a safe emergency-care journey. Evaluate both the care supported by the record and the quality of documentation. Use findings to guide education, competency validation and measurable improvement.

This is an original guidance document and suggested internal checklist informed by public Joint Commission resources and Mayo Clinic and Cleveland Clinic quality principles. It is not an official, endorsed or validated instrument from those organizations. Their names do not imply adoption of their internal nursing audit criteria.

Joint Commission National Performance Goals took effect in 2026 for Hospital and Critical Access Hospital programs. Determine the facility's accreditation program, hospital affiliation and survey scope before treating a requirement as applicable. State law, nursing scope of practice, current accreditation standards and approved facility policies govern local implementation. [1]

Mayo Clinic supports assessing quality through outcomes, processes, safety and patient experience; its nursing model emphasizes collaboration. Cleveland Clinic's public safety approach emphasizes just culture, reporting and improvement of systems. These principles support the review approach here; the checklist wording, sample sizes and scoring are locally adaptable recommendations. [9–13]

How to Conduct a Fair Review

Use one form per encounter. Identify the nurses involved, their assigned roles and the portions of care under review. Read triage, nursing assessments, vital-sign flowsheets, medication administration records, orders, test results, handoffs and discharge or transfer documentation as a timeline. Compare against the policy version in effect on the date of service.

Check nursing recognition and communication of risk, implementation of authorized orders or protocols, and escalation when concerns remain unresolved. Refer diagnostic or prescribing concerns to the Medical Director. Do not assign a physician decision to an RN unless the review concerns a nursing responsibility, such as questioning an unclear order or communicating deterioration.

Missing required documentation is a documentation deficiency; it does not by itself prove care was omitted. Record what the chart supports, what remains uncertain and any corroborating evidence. Hand hygiene performance, bedside medication checks and staffing adequacy may require observation, system logs or staffing records. Do not infer reliable compliance solely from a completed chart field.

Before Local Adoption

Approve the rubric, escalation routes, record-access protections and retention process. Define reassessment intervals, notification deadlines, approved screening tools and age criteria, high-alert medication checks, and review ownership. This template sets no universal minutes-to-treatment or nurse staffing ratio. Calibrate reviewers using the same cases before comparing staff or facilities.

Review Guidance for Checklist Domains A to D

A Arrival and Triage

Look for reliable identification, presentation and arrival time, acuity assignment, initial vital signs and action on urgent findings. Follow the approved acuity tool rather than substituting a retrospective diagnosis for the arrival assessment. Identity checks should use the identifiers required by facility policy; room location is not a patient identifier. [2]

Reviewer prompts: Could another nurse understand how sick the patient appeared? Were red flags communicated promptly? If the patient left early, were the available assessment, notifications and departure circumstances recorded? A nursing triage assessment does not replace the medical screening examination.

B Focused Nursing Assessment

Review a complaint-appropriate assessment, relevant history and baseline function, allergies and reaction type, medication information, and an age-appropriate pain assessment. Include respiratory effort, mental status, perfusion, neurological findings or hydration when relevant. Assess language, sensory, cognitive and caregiver needs that affect safe care. [2, 4, 6]

For pediatric encounters, verify age-appropriate assessment, caregiver participation and weight in kilograms when required for dosing. For older or vulnerable adults, consider baseline cognition, mobility and assistance needs. For time-sensitive presentations, review recognition and pathway escalation, not retrospective independent nursing diagnosis.

C Medication and Treatment Safety

Compare the order or authorized protocol with the administration record. Review patient, medication, dose, route, timing, allergies and relevant pre-administration parameters. Unclear orders, contraindication concerns, omitted doses, refusals and delays should have an explanation and appropriate communication. [3]

For high-alert or weight-based medication, check required calculations, independent checks and monitoring under local policy. Include infusion concentration, rate, titration parameters and administration times when relevant. Do not assume every drug requires the same double-check process. Specimen and medication labeling may require additional observation or electronic evidence.

Reviewer prompts: Were relevant safety concerns resolved before administration? Is there evidence of response and adverse-effect surveillance? A medication charted as given is not, by itself, proof that all bedside verification steps occurred.

D Reassessment and Escalation

Review repeat vital signs, symptoms, pain and response after interventions at the intervals required by the patient's condition and local policy. After opioids or sedating medication, review the indicated respiratory and sedation monitoring, not just a second pain score. Include the period while awaiting a bed or transfer. [2, 4]

Look for who was notified, when, what was communicated, the response and subsequent nursing action. If a concerning finding persisted without an adequate response, review use of the chain of command. A note saying "provider aware" may not explain whether the risk was addressed.

Example: Low oxygen saturation after medication should prompt review of reassessment, clinical status, notifications and interventions. Do not classify the issue as documentation-only until the event timeline has been clarified. An aggregate passing score cannot resolve an unaddressed safety concern.

Review Guidance for Checklist Domains E to H

E Diagnostics and Procedures

Review ordered testing and preparation within nursing responsibility, sample identification and collection, procedure verification, indicated monitoring and post-procedure findings. For critical results, examine receipt, communication and documented follow-through. Escalate uncertainty about test interpretation or treatment decisions to the Medical Director. [2]

When relevant, review point-of-care testing documentation, pregnancy or contrast screening under policy, IV access and device-site checks. For sedation, transfusion or restraints, use the facility's detailed procedure-specific audit in addition to this checklist; record any attachment by case ID.

F Infection Prevention and Patient Safety

Assess chart evidence of infection risks, indicated isolation, device care and risk-based precautions. Review falls, skin injury, elopement, violence and safeguarding concerns where applicable. Chart review should be supplemented by direct observation and environmental audits for practices such as hand hygiene and clean equipment. [5, 12]

For behavioral-health encounters, verify screening under the applicable program and policy, positive-screen escalation for evidence-based assessment, documented risk and mitigation, observation and environmental precautions, reassessment, and safe transition arrangements. Use approved tools and age criteria. Immediate clinical concern still requires action even if routine screening is negative. [7, 8]

For restraint or seclusion, review the applicable authorization, indication, alternatives, monitoring and discontinuation documentation using the dedicated policy. Do not assume a checked box establishes compliance with all required safeguards.

G Discharge and Transfer

Review final nursing condition and vital signs as indicated, unresolved concerns raised before departure, communication of discharge instructions, medication information, follow-up and condition-specific return precautions. Assess understanding using teach-back or another documented method suitable for the patient; record barriers and the steps taken to address them. [6]

For transfers, review the nursing handoff, receiving contact, pending tasks, medication and infusion information, devices, required monitoring, records sent, departure time and condition. Verify ordered transport arrangements were implemented and concerns escalated. Physician acceptance and the transfer decision remain distinct medical responsibilities.

For refusal, leaving against advice or leaving before care is complete, review notifications, care offered, communication of concerns and instructions where feasible. Do not penalize the nurse solely for a patient's decision to leave; evaluate the response within nursing responsibility.

H Documentation and Continuity

Check that entries are attributable, dated, timed, accurate and consistent across notes, flowsheets and the administration record. Reconcile significant discrepancies. Late entries and corrections should follow record-integrity policy; do not alter the original clinical record to make an audit pass.

Review order follow-through, explanation of unfinished care, shift handoffs and assignment of pending results or tasks. A complete review distinguishes nursing performance, shared team responsibilities, workflow barriers and unavailable evidence. Protect patient and staff information in reports and use de-identified case IDs for broader trend presentations.

Scoring Findings and Improvement Follow Through

Suggested Internal Scoring

Response	Meaning
2 Meets	All applicable components supported; care and documentation meet the defined rubric.
1 Partial	Some components met; an improvement is needed without a major identified failure.
0 Does not meet	Required element absent, major deficiency, or important safety concern.
N/A	Element genuinely does not apply; state the reason when not self-evident.

There are 32 equally weighted rows. Maximum applicable points = 2 × (32 − N/A rows). Percentage = earned points ÷ maximum applicable points × 100. If all rows are N/A, record “not scorable.” Example: 4 N/A rows leave 56 possible points; 50 points = 89.3%. Do not use N/A for missing required documentation. For unavailable source records, flag the review as incomplete and obtain them before final scoring.

Suggested categories: 95–100% Excellent; 90–<95% Meets expectations; 80–<90% Improvement needed; below 80% Director follow-up. These are proposed internal thresholds, not Mayo Clinic, Cleveland Clinic or Joint Commission scoring requirements. Do not round upward to change category. For grouped rows, score all applicable components together and identify the failed component on Page 2.

Findings That Override the Total Score

Promptly escalate suspected failure to recognize or respond to deterioration, serious medication error, unaddressed critical result, patient identification error, unsafe transfer or discharge, suicide or elopement safety breach, serious fall or injury, unexpected death, or possible abuse or neglect. Use immediate safety and reporting pathways; do not wait for the monthly audit. A high score does not establish that care was safe.

Monthly Review Process

Adopt a representative sample across nurses, shifts, acuity, age groups and dispositions, plus a separate targeted safety-event sample. One possible starting point is 10 encounters per facility per month, adjusted to volume and risk; this is not a mandated sample size. Track nursing coverage over a rolling period so a small sample is not misrepresented as a comprehensive individual evaluation.

Discuss findings with involved staff using the event timeline and policy. Separate documentation, clinical care, system and unresolved-evidence findings. Route nursing competency concerns through nursing leadership, education and applicable nursing peer-review processes. Physician OPPE/FPPE processes are not automatically the process for RN review. [12]

Action and Remeasurement

Assign an owner, due date, measurable target and follow-up date. Example: After a reassessment documentation gap, review the workflow with staff, revise the reminder if appropriate, and review 10 additional eligible encounters using the same policy interval. Record the numerator and denominator, outcome and closure decision; continue follow-up if improvement is not sustained.

Suggested dashboard: eligible encounters with timely reassessment; critical-result communications meeting policy; documented handoffs; medication events; falls or safety events; patient communication complaints; and completed actions. Define each denominator and data source. Combine process findings with safety and patient-experience data rather than ranking nurses by a small chart-score sample alone. [9, 10]

Reference Library and Source Map

Public sources reviewed September 11, 2026. The following resources inform this original tool; they do not establish that every checklist row is an accreditation requirement. Consult the full current standards for the facility's program and applicable state nursing and facility rules.

[1] **Joint Commission. National Performance Goals. Hospital and Critical Access Hospital programs, effective January 1, 2026.**

Accreditation framework and links to full program chapters; verify applicability to the facility.

Open source

[2] **Joint Commission. NPG 1 Right Patient, Right Care.**

Patient identification, critical results, handoffs and response to changes in condition.

Open source

[3] **Joint Commission. NPG 14 Effectively Managing Medications.**

Medication information, labeling and safe medication systems.

Open source

[4] **Joint Commission. NPG 6 Pain Management.**

Assessment, reassessment, multimodal care and monitoring for opioid-related harm.

Open source

[5] **Joint Commission. NPG 5 Preventing and Controlling Infection.**

Infection prevention program and safe care processes.

Open source

[6] **Joint Commission. NPG 7 Safe Informed Care.**

Patient rights, understandable communication and participation in care.

Open source

[7] **Joint Commission. NPG 8 Reducing the Risk for Suicide.**

Validated screening, indicated assessment, risk mitigation and transition planning.

Open source

Reference Library Continued

[8] **Joint Commission. Suicide Risk Reassessment. Standards FAQ, updated April 21, 2026.**

Policy-based reassessment and clinical evaluation of changing risk.

Open source

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

Public model integrating outcomes, evidence-based processes, safety and patient experience.

Open source

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

Outcome and process measures and patient experience; basis for a balanced review dashboard.

Open source

[11] **Mayo Clinic. Nursing Overview.**

Public description of collaborative nursing practice and the patient experience.

Open source

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

Just culture, reporting, fall prevention, leadership learning and system improvement.

Open source

[13] **Cleveland Clinic. Clinical and Practicum Nursing What Sets Us Apart.**

Public nursing priorities, patient safety, quality and support for nursing practice.

Open source

Checklist source map: A [2]; B [2, 4, 6]; C [3]; D [2, 4]; E [2]; F [5, 7, 8, 12]; G [2, 6]; H [2, 9–13]. Sources provide thematic support; the specific audit language is a suggested local operationalization.

Abbreviations: RN, registered nurse; MAR, medication administration record; QAPI, Quality Assessment and Performance Improvement; MSE, medical screening examination; NPG, National Performance Goal; AMA, against medical advice; LWBS, left without being seen; LBTC, left before treatment complete.