# Freestanding Emergency Room Nursing Director Monthly Chart Review Checklist

Facility: _____ Review month: _____ Reviewer: _____

Encounter ID: _____ Date of service: _____ Nurse(s) / roles: _____

Chief complaint: _____ Age: _____ Shift: _____ Policy / rubric version: _____

Sample: ☐ Routine ☐ Targeted Disposition: ☐ Discharge ☐ Observation ☐ Transfer ☐ AMA/LWBS/LBTC ☐ Other

### Page 1 Nursing Chart Review and Scoring

2 = Meets 1 = Partially meets 0 = Does not meet N/A = Not applicable. Select one response per row.

Use the guidance rubric. Explain 0/1 scores on Page 2. Missing required documentation is not N/A.

| Review element | 2 | 1 | 0 | N/A |
|---|---|---|---|---|
| **A Arrival and Triage** | | | | |
| A1 Patient identification and arrival information complete | ☐ | ☐ | ☐ | ☐ |
| A2 Complaint and acuity documented using approved triage process | ☐ | ☐ | ☐ | ☐ |
| A3 Initial vital signs recorded and urgent abnormalities addressed | ☐ | ☐ | ☐ | ☐ |
| A4 Urgent needs recognized and communicated without avoidable delay | ☐ | ☐ | ☐ | ☐ |
| **B Focused Nursing Assessment** | | | | |
| B1 Complaint-focused assessment and relevant history documented | ☐ | ☐ | ☐ | ☐ |
| B2 Allergies and medication information obtained or barriers addressed | ☐ | ☐ | ☐ | ☐ |
| B3 Pain assessed with appropriate tool and patient needs considered | ☐ | ☐ | ☐ | ☐ |
| B4 Age, language, cognition and assistance needs addressed | ☐ | ☐ | ☐ | ☐ |
| **C Medication and Treatment Safety** | | | | |
| C1 Orders or authorized protocols verified; concerns clarified | ☐ | ☐ | ☐ | ☐ |
| C2 MAR supports correct medication, dose, route and timing | ☐ | ☐ | ☐ | ☐ |
| C3 Required high-alert or weight-based safety checks supported | ☐ | ☐ | ☐ | ☐ |
| C4 Omissions, delays, refusals and adverse reactions addressed | ☐ | ☐ | ☐ | ☐ |
| **D Reassessment and Escalation** | | | | |
| D1 Vital signs and symptoms reassessed at indicated intervals | ☐ | ☐ | ☐ | ☐ |
| D2 Pain and treatment response reassessed within policy | ☐ | ☐ | ☐ | ☐ |
| D3 Required respiratory, sedation or other monitoring documented | ☐ | ☐ | ☐ | ☐ |
| D4 Deterioration escalated with response and follow-through recorded | ☐ | ☐ | ☐ | ☐ |
| **E Diagnostics and Procedures** | | | | |
| E1 Ordered tests and preparation completed or delays escalated | ☐ | ☐ | ☐ | ☐ |
| E2 Specimen identity, collection and handling supported as required | ☐ | ☐ | ☐ | ☐ |
| E3 Procedure checks, device care and monitoring documented | ☐ | ☐ | ☐ | ☐ |
| E4 Critical results communicated and follow-through documented | ☐ | ☐ | ☐ | ☐ |
| **F Infection Prevention and Safety** | | | | |
| F1 Indicated isolation and infection/device precautions addressed | ☐ | ☐ | ☐ | ☐ |
| F2 Falls, skin, elopement and other applicable risks addressed | ☐ | ☐ | ☐ | ☐ |
| F3 Suicide screening, escalation and precautions addressed if indicated | ☐ | ☐ | ☐ | ☐ |
| F4 Required observation or restraint safeguards documented if applicable | ☐ | ☐ | ☐ | ☐ |
| **G Discharge and Transfer** | | | | |
| G1 Final nursing condition assessed; unresolved concerns escalated | ☐ | ☐ | ☐ | ☐ |
| G2 Instructions, medicines, follow-up and return precautions reviewed | ☐ | ☐ | ☐ | ☐ |
| G3 Understanding and communication barriers addressed | ☐ | ☐ | ☐ | ☐ |
| G4 Transfer/shift handoff or early-departure process documented | ☐ | ☐ | ☐ | ☐ |
| **H Documentation and Continuity** | | | | |
| H1 Entries dated, timed, attributable and completed under policy | ☐ | ☐ | ☐ | ☐ |
| H2 Notes, flowsheets and MAR internally consistent | ☐ | ☐ | ☐ | ☐ |
| H3 Orders and unfinished care have documented follow-through | ☐ | ☐ | ☐ | ☐ |
| H4 Pending tasks/results and continuity needs communicated | ☐ | ☐ | ☐ | ☐ |

Earned ____ / Max applicable ____ × 100 = ____% N/A rows ____ Maximum = 2 × (32 − N/A rows)

☐ 95–100% Excellent ☐ 90–<95% Meets ☐ 80–<90% Improvement ☐ <80% Follow-up ☐ Incomplete/not scorable

**Internal suggested thresholds. Serious safety findings override the score. See companion guidance and sources.**

# Page 2 Nursing Director Findings and Action Plan

Facility: _____ Encounter ID: _____ Review date: _____

### 1 Clinical Safety Determination

☐ No concern identified ☐ Documentation gap ☐ Nursing care concern ☐ System concern ☐ More evidence needed

Assessment appropriate? ☐ Yes ☐ Partial ☐ No ☐ Unclear Reassessment timely? ☐ Yes ☐ Partial ☐ No ☐ N/A
Escalation appropriate? ☐ Yes ☐ Partial ☐ No ☐ N/A Transition concerns addressed? ☐ Yes ☐ Partial ☐ No ☐ N/A

### 2 Safety Triggers and Immediate Response

☐ None ☐ Deterioration/delay ☐ Medication event ☐ Critical result ☐ Wrong patient ☐ Unsafe discharge/transfer
☐ Suicide/elopement risk ☐ Fall/injury ☐ Unexpected death ☐ Abuse/neglect concern ☐ Other: _____

Immediate protection / escalation taken: _____
Person notified: _____ Date/time: _____ Event reference: _____

Preventability: ☐ No ☐ Possible ☐ Probable ☐ Yes ☐ Unable to determine ☐ N/A Do not wait for monthly review.

### 3 Evidence and Contributing Factors

Row IDs with gaps: _____ Missing records / evidence needed: _____

Concern, chart location and timeline: _____
_____
_____

What went well: _____

Factors: ☐ Knowledge/skill ☐ Workload/staffing ☐ Handoff ☐ Orders ☐ MAR/EHR ☐ Equipment ☐ Supply
☐ Policy ☐ Team communication ☐ Patient/access barrier ☐ Undetermined ☐ Other: _____

### 4 Nursing Leadership Disposition

☐ No further action ☐ Coaching/education ☐ Competency validation ☐ Additional chart review ☐ Process redesign
☐ Nursing peer review per policy ☐ Medical Director referral ☐ QAPI referral ☐ Immediate leadership escalation

Staff discussion completed / planned: _____ Person responsible: _____ Date: _____
Additional review: next ____ eligible charts / by _____ Issue or population: _____

### 5 QAPI Action and Follow Up

Action: _____
_____

Owner: _____ Due date: _____ Follow-up review date: _____

Measure / data source: _____
Baseline: ____ / ____ Target: _____ Sample / time period: _____

Follow-up result: ____ / ____ Date: _____ ☐ Resolved ☐ Continue monitoring ☐ Escalate
Closure rationale / remaining action: _____

### 6 Final Decision and Signature

☐ Meets expectations ☐ Education required ☐ Monitor ☐ Focused nursing review ☐ Safety/QAPI escalation
☐ Review incomplete pending additional evidence

Nursing Director: _____ Signature: _____ Date: _____
Follow-up reviewer / closure approval: _____ Date: _____

Handle completed forms under approved confidential quality-review processes. A label alone does not establish privilege.