

Securing Forensic Patients in the Public Hospital Setting: Part 1

Creating workable security policies to deal with this 'invisible population'

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James Dean convinced the correctional staff at the local jail that he was spitting up blood. He had only a week remaining on a 60-day sentence for forging a check on a former employer. Since it wasn't a violent crime he was sent to the local emergency room for evaluation accompanied by unarmed detention officer. James needed X-rays, so the officer removed his handcuffs and remained outside the room while the films were being taken and developed.

The detention officer was engrossed in conversation with one of the nurses when, suddenly, the inmate rushed past them and was running at full speed through the hospital clad only in a hospital gown. He made it out the door and into a staff parking lot where he attempted to steal the automobile of an arriving employee. The detention officer and a hospital security guard with his gun drawn were in hot pursuit when the security guard stumbled and fired the gun. The bullet narrowly missed the employee's head, but struck the fleeing inmate. Sound too far fetched to be true? It actually happened.

Many community hospitals, medical centers and teaching hospitals today admit a patient population that is rarely publicized, sometimes unacknowledged, and often not sufficiently monitored. These public facilities are usually as ill equipped to provide secure areas to care for forensic (inmate) patients as the hospital staff is to deal with them.

As budgets are cut and prisons become more crowded, penal institutions are increasingly faced with providing constitutionally mandated healthcare to a population that is often among the highest at risk for serious untreated medical conditions. Huge numbers of prisoners have problems with mental health, substance abuse or personality disorders and have often been excluded from healthcare. The lifestyle and habits of individuals who often end up in the correctional system generally does not include healthy habits and preventive care. Thus, by the time they enter the system their bodies are responding to years of drug and alcohol abuse, smoking, and lack of consistent treatment for many chronic as well as acute diseases. Infectious diseases are rampant with HIV, hepatitis, TB and drug-resistant bacteria commonly occurring. While many correctional systems have medical facilities to handle routine healthcare, they are strained to provide the more complicated and involved care these patients require. As a result many are transferred to public hospitals.

Unfortunately there is no primer for either hospital security or medical staff to use in caring for these patients. Many community or university hospitals do not have secure prison wards or units. This article provides some general guidelines that should be taken into consideration by all hospitals that admit forensic patients.

Tip #1: Have a hospital staff member who acts as the point person for correctional facilities.

This individual may or may not be the security director, but it should be consistent. It is not at all unusual for a hospital to have forensic patients from multiple correctional facilities at one time. This means that the patient could be a federal inmate, an inmate in a state prison or one from the county jail. Each of these facilities will very likely have different rules and regulations for handling and guarding their inmates. The actual care of these patients probably won't differ for the medical and nursing staff, but the hospital liaison should know the differences and identify the channels of communication.

The liaison should ensure that hospital administration and security have the contact information for the key correctional facility personnel. This includes the direct telephone numbers for the warden or jail director, the medical director of the correctional facility, the company that performs the utilization review function and a contact at the correctional facility that will receive the inmate upon return. Periodic meetings should occur between key hospital representatives and those of the correctional facility. This ensures that lines of communication are kept open and any changes in contacts, procedures, or processes are shared. Prison and healthcare administrators must have continuous dialogue to identify conflicting issues that impact the care of forensic patients and the safety of other patients and staff.

Case Study: *John Hilton, Director of Security at a major medical center was shocked when he discovered that the patient in room 63251 was an unescorted inmate on community furlough. Unfortunately, he discovered it only after the inmate had assaulted one of the hospital physicians who gave him a diagnosis he didn't want to hear. It seems the inmate had a personality disorder characterized by violent outbursts. He had been doing so well at the detention facility that the correctional staff felt he deserved to be on medical release.*

Tip #2: Make sure your hospital has a "Forensic Patient Policy" or a "Care of Patients in Custody of Law Enforcement Policy", and that all correctional facilities using your hospital have a copy. Even more importantly, make sure your staff is familiar with the policy.

Most correctional officers providing security for forensic inpatients are receiving over-time pay, and providing security for their patients becomes very cost intensive in terms of productivity and budget for the correctional facility.

As a means of reducing these expenses, facilities often place pressure on physicians to discharge forensic patients back to the correctional facility as quickly as possible. Other times they will provide one correctional officer when two would be more appropriate. In addition, they will send certain inmates to the medical facility unaccompanied by any correctional officers. Indeed, I have seen them send a "community furloughed" inmate to pick up another one from a hospital at discharge.

Hospitals should also determine their approach to the care of *trustee* or *community furloughed forensic patients*. Many correctional facilities do not want to provide correctional officer coverage for these patients. Often, the patient is sent to the hospital for care unaccompanied by officers and left to their own recognition. It is not uncommon for these patients to begin acting out and harassing nursing staff. If this occurs, the hospital security director or supervisor should immediately contact the correctional facility and demand correctional officers be assigned immediately and remain with the forensic patient until he is transferred back to the correctional facility.

Depending upon the crime and the level of security, a forensic patient may have one, two or as many as four correctional officers at any given time. A female correctional officer should always accompany female inmates, even if other officers are male. Make sure that it is well understood by the correctional facility and the hospital staff that hospital security personnel will not provide coverage or relief for correctional officers accompanying forensic patients. Under no circumstances should the hospital assume responsibility for the security of forensic patients. Indeed, should an inmate patient attempt to escape, no hospital staff members should ever attempt to stop or apprehend the inmate. They should only try to ascertain the direction the inmate is taking and keep staff and visitors out of the way.

Budget cuts at the Federal Bureau of Prisons has led them to employ contract guard services to provide security coverage for certain classes of their inmates requiring acute care hospitalization at civilian facilities. Hospitals serving this population should ask for the qualifications and for any firearm certifications for the security guards accompanying Federal inmate patients.

Case Study: *Gerald Hammond, Director of Public Safety at a large medical center in the Midwest was caught off guard when he was approached by a JCAHO surveyor during an unannounced visit, and asked for documentation of their orientation and education of forensic staff accompanying inmate patients. He was certain he had never seen that in the JCAHO Environment of Care standards. He was correct. It is found in the Human Resources standards (HR 2.10-8.) Gerald's hospital was found "out of compliance."*

Tip #3: JCAHO standards require that correctional officers guarding forensic patients receive orientation and education including procedures for responding to unusual clinical events and incidents, the hospital's channels of clinical, security and administrative communication, and distinctions between administrative and clinical restraints. This "C" standard requires data collection as a means of proving this is occurring.

Hospital security departments should require that all correctional officers stop at a central location (the security office) to receive printed information orienting the officers to the meanings of the various codes (Code Blue, Code Red, Code Gray, etc.,) the RACE and PASS procedures, HIPAA and any isolation requirements prior to assuming their post. Documentation of the orientation, the name of the correctional officer and facility should be kept on file. In addition, the security department staff should make periodic audits of correctional officers to assure that all who guard forensic patients have received the orientation information and are documented.

[**Editor's note:** In the second part of this article on securing hospitals for forensic patients, Pamella Carter will look at general guidelines for the care of forensic patients and will present a forensic patient bill of rights.]

About the Author: [Pamella G. Carter](#), RN, BSN, MA, ACM, is an internationally recognized healthcare consultant and co-founder of [Security Assessments International](#). Pam is a senior consultant with SAI and director of clinical and regulatory affairs. As a Registered Nurse (R.N.), Pam has over 35 years experience in nurse management, nursing education, home health, occupational health, acute care, and case management. Her expertise includes extensive experience with both CMS and JCAHO regulatory standards for acute care. Pam has consulted on forensic patient practices at the local, state and federal level and is one of the nation's leading experts on the safe care for inmate and forensic patients in the acute care setting. She was one of the first RNs in the nation to be certified as an Accredited Case Manager by the American Case Management Association. Pam has consulted with the United Kingdom's National Health Service for the past several years and is currently working with the NHS on several major projects. Pam can be reached at pam@saione.com.