# Securing Forensic Patients in the Public Hospital Setting: Part 2

A look at the guidelines and patient's rights issues when working with this 'invisible population'

**When forensic patients come to your hospital, a well-organized plan for communicating guidelines, needs and patient restrictions is paramount to your hospital's security.**

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[**Editor's Note:** The first part of this article series appeared in December on SecurityInfoWatch.com. The earlier portion of this article can be accessed **here**.]

*Marty Martinez was a man who spent his life looking for opportunities, and intensely disliked serving time. One day he managed to dismantle his jail cot and swallowed one of the flat bedsprings. When he began to complain of severe abdominal pain he was taken to the local hospital where X-rays revealed the foreign body in his stomach. Endoscopy and a gastroenterologist's deft touch removed the bedspring. Marty was shocked that evening when the nurse entered his room to give him his discharge instructions. A lax correctional officer who had been dozing while working over time, reacted too slowly as Marty grabbed the nurse in an escape attempt. He was finally apprehended in a wooded area a block from the hospital. The nurse was not physically injured, but was out of work for several weeks due to stress.*

**General Guidelines**

To prevent the kinds of scenarios like the one above and ones in the previous article, it is strongly advised that hospital operations and security staff follow some standard guidelines in the handling of forensic patients.

Hospital security staff should maintain a daily list of all forensic patients in their facility. However, no forensic patient should be listed in the hospital's patient information listing or posted by the patient's room door, and should never be acknowledged to any callers to the security department, nursing unit or switchboard.

Telephone calls from the correctional facility to the hospital about specific forensic patients can be handled by using an agreed upon *password* to ensure that any information is given to appropriate authorities. Prison requests for specific medical information should be made to the attending physician, the nursing supervisor or the case management department, and should be agreed upon in advance.

The hospital staff does not need to know the crime(s) of the forensic patient. It serves no purpose and has the potential to affect the care rendered by even the most conscientious caregiver.

Forensic patients are usually not allowed telephone calls or visitors unless approved by the prison warden. The correctional officers will be aware of who has this approval. The warden will communicate with the families of inmates and provide contact information for the physician.

It is often very helpful to hospital staff for the administration to devise some type of indicator or code that will appear on hospital census to indicate that a particular patient is a forensic patient. One of the most effective that I have seen is a *specific middle name* that all forensic patients share.

Hospital staff must also understand that JCAHO and CMS do not require the same monitoring and documentation of the physical restraints employed with forensic patients that are required for the behavioral or medical restraints that are closely monitored for other patients. Forensic restraints should only be removed for medical treatment, and be replaced as quickly as possible. Some correctional policies require that one correctional officer must have a weapon drawn while a second officer removes or replaces restraints on certain inmates.

***Case Study:*** *Captain Ben Smith was astounded one day when he was making his rounds on his correctional officers and inmates at a community hospital. The nursing staff was holding a birthday party for one of the inmate patients, complete with balloons, cake and gifts! The manipulative inmate and lax custody officers were immediately returned to the correctional facility and disciplined. The nursing staff was reoriented to the care of inmate patients.*

Nursing and other hospital staff caring for forensic patients must continually negotiate the boundaries between the cultures of custody and caring. They should receive specific information about caring for these patients during their orientation and on an annual basis. For example, forensic patients should never be given specific dates or times of discharge, or when they will leave their assigned unit for tests or procedures. They should have food served on disposable plates and utensils and should never have extra supplies or items left in their rooms. Forensic patients should only be given combs, toothbrushes or safety razors with the approval of their correctional officers. All staff members are cautioned against giving any personal information to forensic patients or having contact with them once they have been discharged.

Most importantly, staff must remember that correctional officers must always have the inmate in their line of vision. They cannot assist the staff with patient care, because this can be distracting from their primary duty.

**Forensic Patient Rights**

Forensic patients have most of the same basic patient rights as other patients. They have the right to refuse tests, care, procedures and medications. They have the right to patient education, to sign their own informed consents and to execute "Do Not Resuscitate" documents. While correctional officers must keep these patients within their line of sight at all times, forensic patients have the right of privacy when discussing medical diagnoses with their physicians. The physician can request that the officer step away from the patient or out of immediate earshot as long as the officer can have an unobstructed view of the patient.

Delivering healthcare to inmates is carefully balanced against the need for security and is affected by the values of correctional staff, staff education, nursing and organizational practices. Hospitals must strive to assure the best possible health outcomes for inmate patients, the integrity of health care and the safety of everyone involved.

It is often overwhelming and sometimes confusing to review a policy and procedure and determine what needs to be done, and who is responsible for completing various actions. I suggest the following spreadsheet concept (see links below) which can help keep everyone on target and define what needs to be addressed, who is responsible, the target date for implementation and any measures or evaluation of effectiveness.

The *Forensic Patient Action Plan* spreadsheet describes nine of the most commonly identified problems and concerns that arise when dealing with Forensic Patients. It suggests a plan of action for each problem and shows the individual(s) and/or department(s) that typically have responsible charge for addressing these problems. Blank fields are provided for entering the Target Date of Implementation and an Evaluation of Effectiveness of the proposed plan of action.

The spreadsheet has been posted on SAI's website. To view or print an action plan for dealing with forensic patients, you can access either the **Forensic Patient Action Plan (web/HTML version)** or the **Forensic Patient Action Plan (downloadable Microsoft Excel version)**.

While this article does not cover all of the issues or concerns that may arise in the care of the inmate patient, it is important to remember that these patients can be cared for in an acute care hospital setting with the proper preparation.

**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**.

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