



The Emerging Role of Virtual Nursing and Remote Patient Monitoring in Forensic Medicine: A Narrative Review

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Abstract

Virtual nursing and remote patient monitoring (RPM) are transforming healthcare delivery, with growing relevance to forensic medicine. This narrative review synthesizes evidence from 2016–2026 on their integration into forensic nursing, teleSANE (telehealth Sexual Assault Nurse Examiner) services, violence documentation, correctional health, and forensic psychiatry. Key applications include real-time remote guidance for medical-forensic examinations, hub-and-spoke telehealth models that expand access in rural and underserved areas, passive and active RPM in high-secure settings, and augmented-reality-assisted evidence collection. Benefits encompass improved quality of care, higher provider confidence, reduced patient transfer, enhanced evidence integrity, and better equity of access. Challenges include technological, legal, ethical, privacy, staffing, and sustainability barriers, as well as questions of evidence admissibility and medicolegal liability. Two tables summarize model comparisons and outcome domains; two conceptual figures illustrate the teleforensic workflow and an integrated virtual nursing–RPM framework. Overall, virtual modalities show strong promise for advancing trauma-informed, patient-centered forensic practice while requiring robust standards, training, evaluation, and interdisciplinary collaboration. Further rigorous research on patient outcomes, cost-effectiveness, and legal robustness is essential.

Keywords: irtual nursing; Remote patient monitoring; Forensic medicine; TeleSANE; Teleforensics.

Introduction

Forensic medicine and forensic nursing operate at the intersection of clinical care, evidence collection, legal proceedings, and public health responses to violence, trauma, and death [1,2]. Traditional models rely on in-person specialized examiners, yet geographic maldistribution of Sexual Assault Nurse Examiners (SANEs), forensic pathologists, and related experts creates substantial access disparities, particularly in rural, remote, and resource-limited settings [3,4]. Parallel advances in telehealth, virtual nursing, and remote patient monitoring (RPM) have accelerated since the mid-2010s and were markedly expanded by the COVID-19 pandemic [5,6].

Virtual nursing encompasses remote delivery of nursing assessment, education, care coordination, documentation support, and clinical coaching, often via centralized hubs supporting bedside or community clinicians [7,8]. RPM involves continuous or intermittent collection of physiologic, behavioral, or environmental data through wearables,

sensors, or connected devices, with transmission to remote clinicians for surveillance and intervention [9,10]. In forensic contexts these technologies support real-time guidance during medical-forensic examinations, quality assurance of evidence collection, monitoring of high-risk forensic psychiatric or correctional populations, and documentation of injuries without requiring expert presence on every site [11–15].

This narrative review examines the emerging role of virtual nursing and RPM in forensic medicine. It maps applications, synthesizes reported benefits and limitations, addresses legal–ethical considerations, and identifies research and practice priorities for 2016–2026 and beyond.

2. Methods

A narrative review approach was adopted to integrate heterogeneous literature spanning clinical, technological, legal, and implementation domains. Searches of PubMed, Scopus, CINAHL, Google Scholar, and relevant gray literature (government

reports, professional association documents) covered January 2016–early 2026. Search terms combined “virtual nursing,” “remote patient monitoring,” “telehealth,” “teleSANE,” “teleforensic,” “forensic nursing,” “forensic medicine,” “medicolegal,” “correctional health,” and related variants. Inclusion prioritized peer-reviewed studies, program evaluations, scoping/systematic reviews, and high-quality reports describing virtual or remote modalities applied to forensic examination, violence documentation, or forensic populations. Exclusion focused on purely technical device papers without clinical–forensic linkage and pre-2016 material. Approximately 45 key sources were selected for synthesis; reference lists of included works were hand-searched. Findings are organized thematically rather than by formal meta-analysis given the predominance of descriptive, qualitative, and implementation studies.

3. Conceptual Foundations

3.1 Forensic Nursing and Medicine

Forensic nursing applies nursing science to legal proceedings and care of victims and perpetrators of trauma, violence, and abuse [1,16]. Core activities include medical-forensic examination, injury documentation, evidence collection and preservation, chain-of-custody maintenance, trauma-informed support, and expert testimony [2,17]. Forensic medicine more broadly encompasses clinical forensic examinations of living persons, death investigation, and medicolegal consultation [18].

3.2 Virtual Nursing

Virtual nursing models range from task-focused remote documentation and education support to fully integrated team-based virtual acute care nursing that partners with bedside staff [7,8,19]. Staffing ratios, workflow design, and technology platforms vary; effectiveness depends on alignment with operational context rather than a single optimal ratio [8]. In forensic settings the analogous model is the hub-and-spoke teleSANE or teleforensic nurse examiner configuration, in which an experienced remote specialist guides an on-site clinician in real time [11,12,20].

3.3 Remote Patient Monitoring

RPM technologies include wearable sensors for vital signs, activity, sleep, and location; continuous glucose monitors; digital stethoscopes; and passive camera- or radar-based systems that avoid continuous physical contact [9,10,21]. In forensic psychiatry and high-secure hospitals, passive remote monitoring has been evaluated for safety observation while balancing privacy and least-restrictive principles [22]. In correctional settings, RPM supports chronic disease management and withdrawal monitoring without frequent physical transfers [23].

4. Applications in Forensic Practice

4.1 TeleSANE and Medical-Forensic Examinations for Sexual Assault and Violence

The most developed application is telehealth-supported sexual assault forensic examination. Hub-and-spoke models place an International Association of Forensic Nurses (IAFN)–certified SANE at a central hub who provides live video guidance to local-site clinicians (often emergency or primary-care nurses with basic training) performing the examination [11,12,20,24–26]. Programs such as the Sexual Assault Forensic Examination Telehealth (SAFE-T) Center, Texas Teleforensic Remote Assistance Center (Tex-TRAC), National TeleNursing Center, and emerging national Teleconnect initiatives demonstrate feasibility across rural, military, tribal, and underserved sites [12,24,27,28].

Reported outcomes include statistically significant increases in local nurse confidence, high patient satisfaction and perceived quality, protocol standardization, and improved examination quality on external expert review [12,24,29]. Real-time guidance supports proper evidence collection, injury documentation, trauma-informed communication, and referral [20,30]. Asynchronous elements (secure image or data review) complement synchronous consultation [3]. Pediatric applications are emerging with specific recommendations for qualifications, acute-case focus, and expert case review [31].

Augmented-reality platforms such as ARMED (Augmented Reality Assisted Medical Evidence Collection and Documentation) extend telementoring by allowing remote forensic experts to overlay guidance and annotations during examinations of violence victims, improving injury recognition and documentation fidelity [13,32].

4.2 Correctional and Detention Settings

Remote presence technology has been explored for healthcare delivery in police detention centers, linking custody environments to emergency or specialist services and addressing role conflict, risk, and resource barriers [14]. In prison and forensic mental-health networks, virtual care models deliver primary care, mental health, and specialty consultation while reducing transport risks and costs [33]. RPM devices for vital signs, glucose, and cardiac monitoring have been piloted in correctional systems to support withdrawal management and chronic disease care [23]. Figure 1 shows the conceptual workflow of a hub-and-spoke teleforensic examination.

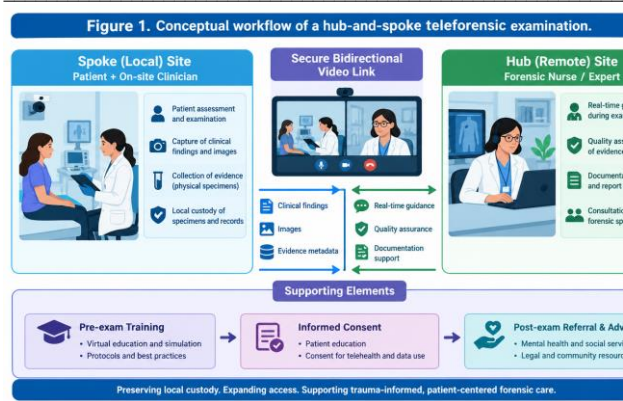


Figure 1. Conceptual workflow of a hub-and-spoke teleforensic examination.

4.3 Forensic Psychiatry and High-Secure Environments

Passive remote monitoring technologies (e.g., contactless sensors for vital signs, movement, and sleep) have undergone service evaluation in high-secure forensic psychiatric hospitals. Qualitative findings highlight potential for enhanced safety observation, reduced night-time disturbance, and staff reassurance, balanced against privacy concerns and the need for clear escalation pathways [22]. Mobile and wearable approaches for outpatients under forensic supervision are under early investigation for medication adherence, activity, and early detection of deterioration [34].

4.4 Broader Medicolegal and Death-Investigation Contexts

Remote consultation supports triage, second opinions, and documentation review in clinical forensic examinations of living persons [18,35]. Digital photography, electronic health-record integration, and secure data portals facilitate chain-of-custody-compatible evidence handling [15,36]. Virtual communities of practice and online education platforms support continuous professional development of forensic nurses [37,38].

5. Benefits

Access equity is a primary benefit: patients in rural or low-resource areas receive expert-guided care without prolonged travel or transfer, preserving local continuity and reducing secondary trauma [3,4,12,20]. Quality and standardization improve through real-time protocol adherence and expert oversight [12,24,29]. Provider confidence and skill acquisition rise, supporting workforce retention and capacity building [12,24]. Patient experience metrics are generally favorable, with high ratings of care quality and comfort [12,24]. Operational gains include reduced length of stay or transfer costs in some models and efficient use of scarce specialist time [7,8]. Evidence integrity can be enhanced by guided collection and contemporaneous documentation [13,30].

6. Challenges and Limitations

Technological barriers include connectivity reliability, equipment cost, interoperability, and user interface design suited to high-stakes forensic environments [20,26]. Human factors encompass role clarity between hub and spoke clinicians, training requirements, and potential deskilling or over-reliance [14,20]. Legal and regulatory issues involve licensure across jurisdictions, scope of practice, informed consent for tele-examination, privacy (HIPAA/GDPR equivalents), and the evidentiary status of remotely guided examinations and digital records [18,35,39]. Medicolegal liability frameworks developed for in-person encounters require adaptation to continuous or remote data streams and distributed responsibility [39]. Sustainability depends on funding, reimbursement, staffing models, and ongoing quality assurance [20,26]. Equity risks persist if technology access or digital literacy is uneven. Empirical gaps remain regarding long-term patient outcomes, cost-effectiveness, diverse populations, and courtroom performance of teleforensic evidence [20] (Table 1 and Table 2).

Table 1. Comparison of Principal Virtual Nursing and RPM Models in Forensic Contexts

Table 1. Comparison of teleforensic models and their key features.

Model	Setting / Structure	Key Features	Advantages	Limitations
Hub-and-Spoke Teleforensic Model	Central expert hub with multiple local sites (spokes)	- Real-time video consultation - Remote guidance and QA - Shared digital records - Local evidence collection	- Expands access to specialists - Reduces patient transfer - Improves evidence quality - Cost-effective	- Dependence on technology - Requires training - Potential connectivity issues
TeleSANE Model	Remote Sexual Assault Nurse Examiner support (via telehealth)	- Virtual examination guidance - Evidence collection coaching - Real-time documentation 24/7 availability (in some sites)	- Increases SANE access - Improves provider confidence - Enhances patient comfort - Maintains forensic standards	- Limited to non-urgent cases - Legal variances across regions - Reimbursement challenges
Remote Monitoring Model (Forensic Populations)	Continuous or intermittent monitoring (correctional, forensic psychiatric, high-risk individuals)	- Wearables and sensors - Behavioral/physiological data - Alerts to remote clinicians - Teleconsultation and intervention	- Early risk detection - Prevents adverse events - Supports continuity of care - Improves resource allocation	- Privacy and security concerns - Data management burden - Patient acceptance variability
Augmented Reality Model	Remote expert with AR-assisted guidance (during exam or evidence collection)	- Live video with AR overlays - Step-by-step visual instructions - Image annotation - Real-time quality checks	- Improves accuracy and consistency - Supports less experienced staff - Enhances training and education - Better evidence documentation	- High technology costs - Need for robust internet - Learning curve for users
Virtual Nursing Support Model	Centralized virtual nursing team supporting local clinicians and patients	- Assessment and triage - Education and counseling - Care coordination - Documentation assistance	- Improves care coordination - Reduces provider burden - Enhances patient engagement - Supports interdisciplinary care	- Staffing and workload issues - Scope-of-practice variability - Technology and training needs

Table 2. Summary of Selected Outcome Domains from Key Evaluations

Table 2. Summary of Selected Outcome Domains from Key Evaluations (2016–2026)

Domain	Representative Findings	Sources
1. Provider confidence	Significant pre–post increases among local-site nurses after teleSANE support	[12,24]
2. Examination quality	Higher external expert ratings of guided vs. unguided exams; protocol standardization	[24,29]
3. Patient experience	High satisfaction, perception that telehealth improved care, feeling supported	[12,24]
4. Access / utilization	Increased availability of expert guidance; reduced need for transfer	[3,20,27]
5. System change	Multiple protocol and policy adaptations per site	[12]
6. Safety monitoring	Feasibility of passive systems; staff-perceived safety benefits with privacy caveats	[22]

7. Integrated Framework and Synthesis

The models and outcomes summarized above can be conceptualized within a unified framework that links enabling technologies, virtual nursing roles, and RPM functions to forensic and patient-centered outcomes (Figure 2).

Figure 2. Integrated framework linking virtual nursing, RPM, and forensic medicine outcomes.

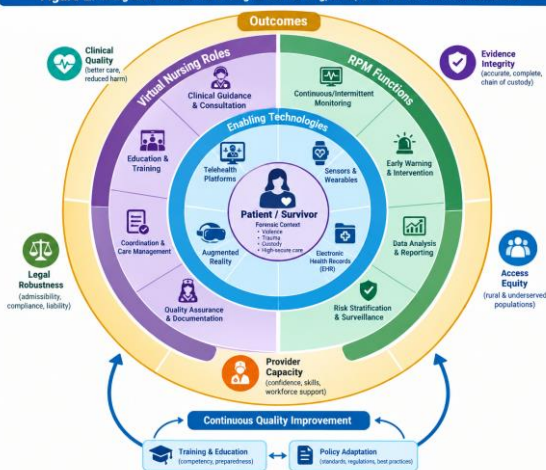


Figure 2. Integrated framework linking virtual nursing, RPM, and forensic medicine outcomes.

8. Legal, Ethical, and Policy Considerations

Informed consent must address the remote nature of consultation, recording policies (many programs explicitly avoid recording the examination itself), data storage, and potential use in legal proceedings [20,30]. Chain-of-custody protocols require clear delineation of what is transmitted versus retained locally [15]. Cross-jurisdictional practice raises licensure and credentialing questions; professional associations and funders are developing guidance and national hub models [28,36]. Liability may attach to system design (staffing, escalation algorithms) as much as individual clinicians, especially with continuous RPM data [39]. Ethical principles of autonomy, non-maleficence, justice, and trauma-informed care remain paramount; technology should not compromise the therapeutic and forensic relationship [16,17].

9. Future Directions

Priorities include: (1) rigorous comparative effectiveness and implementation studies with patient-centered and justice-system outcomes; (2) standardized metrics for teleforensic quality and sustainability; (3) integration of artificial intelligence for triage or anomaly detection under human oversight; (4) expansion beyond sexual assault to intimate-partner violence, elder abuse, child maltreatment, and death investigation support; (5) cost-effectiveness and reimbursement models; (6) inclusive design for diverse populations and low-bandwidth environments; and (7) interdisciplinary education embedding virtual forensic competencies. Professional bodies (e.g., IAFN) and research funders

are already advancing teleconnect infrastructure and toolkits [28,36].

10. Conclusion

Virtual nursing and remote patient monitoring constitute an emerging, evidence-supported extension of forensic medicine and nursing practice. TeleSANE and related telementoring models demonstrably expand access to high-quality medical-forensic care, elevate provider capability, and maintain or improve patient experience. RPM adds continuous surveillance capacity in correctional and forensic-psychiatric settings. Realization of full potential requires attention to technology, human factors, legal-ethical frameworks, sustainability, and rigorous evaluation. When implemented thoughtfully, these modalities advance the dual clinical and justice missions of forensic practice in an increasingly digital healthcare landscape.

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