Provincial Clinical Practice Guidelines

X02: Interfacility Transfer of the Behaviourally Compromised Patient

BC Emergency Health Services

Provincial Health Services Authority

January 2026

Related Policy	Least Restraint C-04-11-85391
Date	January, 2026
Purpose	To provide a consistent procedural approach to the management of an Agitated Medical Emergency
Scope	Applies to all British Columbia Emergency Health Services (BCEHS) clinical staff
Setting	Pre-hospital assessment and treatment
Population	Pediatric and adult patients
Author	BCEHS Practice and Learning Department
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Location	BCEHS Handbook

Disclaimer

The content of this guideline is expressly intended for use by qualified BCEHS clinicians when performing duties during the delivery of patient care, and on behalf of BCEHS.

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Introduction

The purpose of this Clinical Practice Guideline (CPG) is to outline recommendations for the management of behaviourally compromised patients during interfacility transfers by Paramedic and Emergency Medical Responders (EMRs) operating within the British Columbia Emergency Health Services (BCEHS). This CPG applies to both pediatric and adult patients. It is not directly applicable to prehospital events requiring management of the patient experiencing a behavioural emergency but shares the same fundamental concepts that govern the principles of least restraint, consent and decision-making capacity.
(*see CPG G01 Behavioural Emergencies*)

The behaviourally compromised patient

Interfacility transport of behaviourally compromised patients involves unique considerations to ensure patient and provider safety. The patient may require sedation, monitoring for agitation, and specific transport procedures and equipment to prevent escalation of behavioural issues. Clear communication, appropriate documentation, proper restraint methods, and awareness of potential triggers are crucial during these transfers.

An appropriate and standardised pre-transport evaluation involving a risk assessment and **Individualized Transport Plan** will help protect the patient and providers from predictable harm.

These guidelines address the following:

- Pre-transport risk assessment
- Medical management principles for behaviourally compromised patients during IFTs
- Definitions of restraint.
- Policy and legal considerations in the management of the behaviourally compromised patient
- Guidelines for the application and use of restraints in clinical practice

Pre-transport risk assessment

This assessment helps determine the appropriate level of care and resources needed during transport to ensure the safety of the patient and others. It is used to evaluate the potential risks associated with transporting the patient, especially if they are agitated or potentially dangerous.

Each patient identified during the Patient Transfer Network (PTN) intake process as having a past or present safety issue or behavioural compromise **must** have a standardized pre-transport risk assessment completed. A risk assessment should carefully consider patient safety, dignity and capacity for informed consent and be completed in collaboration with the sending and receiving facilities, and BCEHS Clinical Hub advisors (CCP-A, ITT-A, Paramedic Specialist, EPOS).

When necessary, a BCEHS Indigenous Cultural Advisor should be consulted.

BCEHS Pre-Transport Risk Assessment			
	A	B	C
Evaluation	**Ever**	**Within Previous 24 hours**	**Anticipated**
Emotional State (EM): Include if the patient has been suicidal, depressed, anxious, agitated, irritable, hostile, reactive and /or manic	(0-1)	(0-1-2)	(0-1-2)
Mental State (MENT): Include if the patient has been confused, disoriented, cognitively impaired, hallucinating, deluded and/or thought disordered	(0-1)	(0-1-2)	(0-1-2)
Behaviour (BEH): Include if the patient has been threatening or violent to self, others or objects, impulsive, restless, uncooperative with instructions and/or directions	(0-1)	(0-1-2)	(0-1-2)
Subtotal	**/3**	**/6**	**/6**
Total	**/15**		

Note:	**Column A**	No = 0, Yes = 1
	Column B & C	Absent/minimally present = 0 Moderately present = 1 Strongly present = 2

Overall anticipated risk level during transport based on total score			
Total Score	A ≤ 3 AND B + C = 0	A + B = 4-8 OR If in any B ≥ 1	A + B + C = ≥ 9 OR If in any C ≥ 1
Risk of being Disruptive and/or violent during transport	**LOW**	**MODERATE**	**HIGH**

(see Appendix A for larger view)

EMRs/Paramedics should assess level of agitation upon arrival at bedside for **ALL low-risk patients** to confirm continuity with current Pre-transport Risk Assessment.
(See Appendix B)

Medical management principles for interfacility transport of the behaviourally compromised patient.

Patients identified as **moderate to high-risk** require an **Individualized Transport Plan**.

This transport plan should be developed in collaboration with:

- the patient's most responsible clinician
- BCEHS Clinical Hub advisors
- the crew assigned to the transfer

A transport plan should comprehensively address the patient's needs and facilitate a smooth transition between care settings. It should be documented in the patient transfer record and include a detailed patient history, diagnoses if available, treatment goals and include:

- mode of transport
- alternative transport modalities
- required scope of practice of BCEHS crew providing patient care
- sedation goals
- pharmacological management required
- method of restraint if required
- specialised escorts if required

All patients requiring pharmacological management should be continuously monitored throughout transport. Resuscitation equipment must be available at all times. Specific monitoring parameters may include:

- level of consciousness
- blood pressure
- heart rate
- respiratory rate
- oxygen saturation
- capnography
- blood glucose level
- temperature
- electroencephalography (EEG)

A restrained patient must not be placed nor transported in the prone position.
(*see: BCEHS OPS 220 Positioning of Restrained Patients Before and During Ambulance Transportation*)

Definitions of restraint

Restraint is a physical, mechanical, pharmacological, seclusion or environmental measure used to control the physical or behavioural activity of a person or a portion of their body.

Least Restraint is the use of the least restrictive restraint for the shortest duration of time and only when all other options have been exhausted.
(*see Least Restraint Policy*)

Physical Restraint is the act of using one's body to physically restrain or impede another person's movement.

Mechanical Restraint is a method of physical intervention involving the use of authorized equipment. A mechanical restraint restricts the freedom of movement or access to one's own body that it is attached to, adjacent to, or worn by the patient and that the patient cannot remove.

Environmental Restraint is any barrier or device that limits the movement of an individual and thereby confines an individual to a specific geographical area or location.

Pharmacological Restraint is a pharmacological agent given to control sudden aggressive or violent behaviour representing a serious risk of harm to self or others.

When a drug is used to treat specific medical or psychiatric symptoms and is part of a treatment plan, it is not considered a restraint.

The application of a medication to the restrained patient for comfort and pain relief is not considered a form of pharmacological restraint.

Medication administered by the paramedics to provide sedation is a form of pharmacological restraint and must be considered as a component of a least restraint approach

BCEHS policy and legal framework considerations

In accordance with the ***BCEHS Least Restraint Policy***, restraints must only be used in the following situations:

Under the Mental Health Act, at the direction of a Physician

When a patient has been apprehended by the police or similar legal enforcement.

In circumstance when considered necessary to maintain public or personal safety or when a paramedic's or EMR's safety is in question.

When a safety issue is identified prior to transport and the patient is capable and willing to provide their consent to restraint

When a patient is **voluntarily admitted** and is being transported between facilities within the legal framework of the Mental Health Act, the use of restraints may only occur in the following circumstances:

- Patient with decision-making capacity and their consent,
- Patient with impaired decision-making capacity and the consent of the patient's substitute decision maker,
- Patient with impaired decision-making capacity and imminent risk of harm; **no consent required.**

Substitute Decision Maker (SDM) is defined under the Health Care Consent Act as the person(s) authorized to give or refuse consent to treatment on behalf of a person who is incapable with respect to that treatment. Prior documentation is not required to determine an SDM, and the Act provides priority in the order of: spouse, adult child, parent, adult sibling, grandparent, adult grandchild, adult relation by birth or adoption, close friend, immediate relation by marriage ("in-laws").

Capacity to consent is determined based on the capacity to fully understand the treatment and possible consequences of treatment. Informed consent and discussion of rationale for treatment should be documented.

Where consent is being sought, paramedics/EMRs have a duty to take reasonable steps to be satisfied that the patient or substitute decision maker has understood the appropriate information, particularly where there is a language barrier, emotional issues, questions of mental function, or a history of trauma.

Paramedics/EMRs are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g. something in a patient's history or behaviour raises questions about their capacity to consent).

Minors: The capacity to consent is based on maturity, not chronological age. A minor is considered capable of consenting or refusing treatment (**mature minor)** if the physical, mental and emotional development of the minor will allow for a full appreciation of the nature of the consequences of the decision.
(*see: Consent of Minors Infants Act*)

When paramedics/EMRs arrive at bedside they must conduct a thorough assessment of the patient's current condition and ensure all appropriate documentation is prepared.

When there is a change in the patient's condition or presentation, or in the clinical judgement of the paramedic/EMR there is a need to revisit the Individualized Transport Plan they should request a re-conference with the BCEHS Clinical Hub and advisors to discuss a potential modification of the plan.

If such modification to the plan impacts the scope of practice capability of the paramedics or EMRs, or presents an increased risk of harm, this should be discussed during the re-conference.
(*see Right to Refuse Unsafe Work*)

Placing a patient into mechanical restraints and providing treatment without their consent represents a significant suspension of their rights and as such paramedics and EMRs must ensure that such action is justifiable.

Confirming **appropriate documentation** to support **involuntary admission** is necessary before transport of the patient can take place.

Form 4.1 First Medical Certificate (Involuntary Admission)

A legal document used to initiate the involuntary admission of a person to a **designated facility** for treatment. It allows for an **initial 48-hour** period of detention and assessment to determine if further involuntary treatment is necessary. It provides legal authority to detain, apprehend, or transport a person to a designated facility. If signed outside of a designated facility for the purposes of apprehension under the Mental Health Act, it is valid for **14 days** from date of signature.

The form must be signed by a **physician or nurse practitioner** who has personally examined the individual and determined they meet the criteria for involuntary admission.

Once a second signature is applied, the involuntary admission begins for a period of **48 hours**.

Form 4.2 Second Medical Certificate (Involuntary Admission)

This legal document must be completed within 48 hours of the initial admission by a different physician. Once the second medical certificate is completed the person may be admitted as an involuntary patient for up to a month from the day of initial admission.

Form 6 Medical Report on Examination of Involuntary Patient (Renewal Certificate)

Involuntary detention beyond the first month, requires a physician to examine the patient and complete this renewal certificate before the current certificate expires. This certificate is valid for an **additional one month.** Subsequent Form 6 renewals can be applied indefinitely, the second renewal being for a period of **3 months**, and all subsequent renewals for **6-month** periods.

Designated Facility

This refers to specific hospitals or other facilities where a person may be admitted under authority of the British Columbia (BC) Mental Health Act. Generally, a designated facility is a hospital for involuntary inpatients

Within the BC Mental Health Act [s 3(1), (2)], a designated facility can be a Mental Health Facility, hospital designated as a Psychiatric Unit, or hospital designated as an Observational Unit.

Form 5 Consent for Treatment

This form details the consent process for mental health treatment if a patient is involuntarily admitted on a Form 4 or Form 6.

The Form 5 requires that either patient consent to treatment, or the director's authorization (if the patient does not consent), be documented.

Within the BC Mental Health Act, a "director" refers to a person appointed to oversee a designated facility. This also includes anyone authorized by the director to exercise their powers and duties under the Act, such as a physician

Before any medication can be administered (unless it is an emergency situation), either with their consent or against an individual's will without their consent, a Form 5 must be completed.

While a Form 5 does not expire, a new **Form 5 must be completed every time there is a significant change in treatment, such as initiation of restraints, or transfers to a new designated facility.**

This is an important component of the Act as it informs the need for the Form 5 to reflect any ongoing treatment and planned interventions as part of the **Individualized Transport Plan**

Guidelines for the application and use of restraint in clinical practice.

Adequate training in the management of pre-hospital and interfacility transport of behavioural emergencies, is essential.

The decision to restrain a patient is complex and challenging and, can create an ethical and clinical practice dilemma for those providing patient care. This can have an emotional impact for EMRs and paramedics, patients and their family as well as other health care providers and support staff.

Paramedics should also consider the social and cultural impact of restraint on a patient and their family and have regard for the following concepts and philosophies of care within both BCEHS and the wider healthcare system:

Trauma informed practice should be incorporated into all patient care situations with the intent of understanding the prevalence, impact and roll that trauma may have on a patient's emotions and behaviour. An understanding of the ways in which trauma changes an individual's neurobiology, emotional regulation and capacity for adaptive social functioning is specifically relevant when faced with behaviours associated with restraint.

Cultural safety is a patient-centered approach that aims to create a safe and respectful environment for all patients. It involves recognizing and addressing power imbalances that exist between the healthcare provider and the client. Restraints create an automatic power imbalance once applied.

Cultural Humility requires the care provider to acknowledge themselves as a learner when it comes to understanding the patient's experience.

Child/youth centred care relies on treatment that is developmentally appropriate and focuses on individualized care that involves the child/youth as an active participant in the decision-making process whenever possible.

Family/caregiver focused care is based on the philosophy that care involves a partnership between the patient and their family (the recipients of care) and those delivering care.

BCEHS supports a philosophy of least restraint. The over-arching principle in all restraint use is to provide a safer environment in which care can be provided while protecting the patient, providers and public from further harm during the transport.
(*see Least Restraint Policy*)

Patients who are restrained are also at risk of injury from direct pressure on areas of their body and the physical exertion they expend while struggling against restraint.

The use of pharmacological restraint may lessen the need for mechanical restraints and is therefore aligned with the BCEHS Least Restraint Policy.

When considering the use of restraints, EMRs and paramedics are asked to weigh their decisions against the principle of beneficence (doing good) and non-maleficence (avoiding harm) to ensure the patient's well-being.

Whereas the Mental Health Act, is currently silent on the use of restraint, patients who are involuntary admitted within the Act, **may require pharmacological and/or mechanical restraint** for the purpose of interfacility transport. This is because individuals involuntarily admitted are deemed to pose a risk to themselves or others, and restraints are necessary to manage potential aggression, self-harm, or escape attempts during transport.

Appendix A

BCEHS Pre-Transport Risk Assessment			
Evaluation	**A**	**B**	**C**
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Appendix B

The use of standard terminology and a risk assessment that can be understood by all responders is important to maintain continuity, safety and clear communication between all public service agencies on scene. An assessment should only involve the observation of the patient's behaviour and response to de-escalation efforts. Potential causes and attempts to diagnosis should not occur at this stage.

In the context of medical behavioural emergencies, "agitation" refers to a state of excessive psychomotor activity and/or heightened excitability, often accompanied by restlessness, irritability, and potentially violent behaviour.

Rapid decision-making, differences in training and the need for communication between medical and non-medical agencies pose unique challenges within the dynamic pre-hospital environment, making the direct application of sedation and agitation scales impractical. The use of a rapid **Level of Agitation Assessment** can be carried out using an observational-based approach that does not require patient cooperation or participation.

Level of Agitation	Behaviour
Severe	Violent, aggressive, danger to self and others Attacking objects or people Not redirectable Not responsive to verbal de-escalation
Moderate	Physically or verbally threatening No danger to self Extremely active Difficult to redirect
Mild	Agitated Signs of overt physical and verbal activity Redirectable
Calm	No agitation Non-threatening

Appendix C

An **Individualized Transport Plan** ensures safe and efficient interfacility transfer of patients by tailoring the plan to the specific needs of each patient. This plan considers the patient's medical condition, required level of care, and the capabilities of the transporting EMRs/Paramedics, while also addressing logistical and administrative details.

Key Components of an Individualized Interfacility Transport Plan:

- **Patient Assessment and Stabilization:**

  A thorough assessment of the patient's condition, including vital signs, medications, and any specific needs related to their condition (e.g., respiratory support, pain management), is crucial. This may involve ongoing monitoring and optimization of the patient's condition prior to transport.

- **Level of Care Required:**

  Determining the appropriate level of care during transport is essential. This may range from basic life support to advanced critical care, depending on the patient's needs.

- **Destination Facility:**

  The receiving facility must be capable of providing the level of care required by the patient. This involves confirming bed availability and ensuring the receiving team is aware of the patient's condition and anticipated needs.

- **Transport Mode:**

  The mode of transport (ground or air) should be selected based on the patient's condition, distance to the receiving facility, and availability of resources. Ground transport is common for shorter distances, while air transport may be necessary for longer distances or when time is critical.

- **Communication and Coordination:**

  Clear communication and coordination between the sending and receiving facilities, as well as the transport team, are vital. This includes sharing relevant patient information, confirming the plan, and establishing contact during transport.

- **Contingency Planning:**

  A contingency plan should be in place to address potential complications during transport. This may include having medications, equipment, and personnel readily available to manage any unexpected events.

- **Documentation:**

  Comprehensive documentation of the patient's condition, the transport plan, and any interventions during transport is essential for continuity of care.

Examples of Considerations:

- **Sedation Goals:**

  For patients requiring sedation during transport, specific goals and strategies should be discussed with the sending and receiving facility, and transport team
- **Motion Sickness:**

  Patients prone to motion sickness may require anti-emetic medication prior to transport.
- **Mental Health:**

  For patients with mental health conditions, particularly those with a history of aggression or elopement risk, a comprehensive risk assessment should be conducted and treatment plan designed.

Benefits of Individualized Transport Plans:

- **Improved Patient Safety:**

  By tailoring the plan to the individual patient, potential risks during transport can be minimized.
- **Enhanced Efficiency:**

  A well-defined plan ensures a smooth and efficient transfer, reducing delays and optimizing resource utilization.
- **Better Patient Outcomes:**

  By ensuring the patient receives the appropriate level of care at the right facility, individualized plans can contribute to improved patient outcomes.