Provincial Clinical Practice Guidelines

X01: Interfacility Transfers

BC Emergency Health Services

Provincial Health Services Authority

August 2026

Related Policy	-
Date	August, 2026
Purpose	To provide a consistent procedural approach to the transfer of patients between medical facilities
Scope	Applies to all British Columbia Emergency Health Services (BCEHS) clinical staff
Setting	Pre-hospital assessment and treatment
Population	Paediatric and adult patients
Author	BCEHS Practice and Learning Department
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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 provide evidence-based direction for BCEHS Emergency Medical Responders (EMRs) and paramedics conducting interfacility transfers (IFTs) to ensure patient safety, continuity of care, and effective communication between healthcare facilities.

This CPG applies to both paediatric and adult patients during interfacility transfers involving stable, unstable, or critical patients, within ground or air medical transport systems.

These guidelines address the following:

- IFT clinical response model
- Pre-transport assessment
- Medical management principles for IFTs
- Communication
- Documentation
- Components of an Individualized Transport Plan
- Cultural Safety

IFT clinical response model

Transfers are typically arranged when a patient needs a specialized medical intervention or higher level of care not available at the sending facility and are triaged using the following **Clinical Response Model.**

PURPLE
Any critically ill or injured patient who **CANNOT BE STABILIZED** at a sending facility **AND** has an imminent threat to life **OR** requires an immediate diagnostic or therapeutic intervention
RED
Any critically ill or injured patient who **HAS BEEN STABILIZED** at a sending facility but has a high likelihood of deterioration or requires an emergent diagnostic or therapeutic intervention
ORANGE
Any seriously ill or injured patient who **HAS BEEN STABILIZED** at a sending facility but has a moderate likelihood of deterioration or requires an urgent diagnostic or therapeutic intervention
YELLOW
Any acutely ill or injured patient who **HAS BEEN STABILIZED** at a sending facility and has a low likelihood of deterioration but requires a higher level of care
GREEN
Any hemodynamically stable patient who is being transferred for a scheduled appointment with no planned admission
BLUE
Any hemodynamically stable patient who is being repatriated back to the sending facility or for the purpose of decanting a specialty, tertiary, or quaternary site

Levels of intervention are described as:

Immediate: required upon arrival at the receiving hospital.

Emergent: within 4 hours of arrival at the receiving hospital

Urgent: within 12 hours of arrival at the receiving hospital

BCEHS's Patient Transfer Network (PTN) and Patient Transport Coordination Centre (PTCC) work together to manage most transfers.

PTN coordinates with both sending and receiving facilities. Patient transport care requirements are identified at this stage and BCEHS assigns a resource with the appropriate scope of practice. BCEHS Paramedic Advisors (Paramedic Specialist, CCP-A, ITT-A), and BCEHS Medical Practitioner Advisors (EPOS, BCW&C TA) may be asked to assess a patient's clinical requirements and assist in determining an appropriate **Individualized Transport Plan** and resource based upon:

- acuity, complexity and risk of deterioration,
- degree of care of required,
- transport logistics

BCEHS then manages the logistics, including ambulance dispatch and air or ground transport.

Pre-booked interfacility transfers are planned transfers of patients requiring EMR or paramedic care. When care is beyond the scope of practice of an EMR or paramedic, a medical escort (RN, RT, physician) may be requested to accompany the patient depending on clinical needs.

Critical care transfers involve patients who are critically ill or injured and require specialized care, potentially over long distances. This includes transfers of paediatric, neonatal, and high-risk obstetrics patients.

EMRs and paramedics may be assigned to an IFT requiring a pre-transport consultation. Regional ground response paramedics should be prepared

to perform IFTs using an expanded operational scope of practice for the duration of the transport.

Cultural safety

Indigenous cultural safety is crucial for interfacility transport because it ensures respectful and equitable care for Indigenous patients, addressing historical and systemic injustices that can negatively impact their health and well-being. By prioritizing cultural safety within the transport plan, healthcare providers can create a more inclusive and trustworthy environment, ultimately improve patient outcomes and foster positive relationships with Indigenous communities.

To effectively incorporate Indigenous cultural safety and anti-discrimination into transports from Indigenous communities in British Columbia, it is important to adopt a multifaceted approach that prioritizes respect, understanding, and collaboration. This involves EMRs and paramedics having knowledge on cultural protocols, building trust through community engagement, and ensuring equitable access to culturally safe care during transports.

EMRs and paramedics have an opportunity as frontline staff to incorporate their training in cultural safety and humility, anti-racism and Indigenous perspectives into community engagement and collaborative partnerships.

Partnerships with Indigenous Communities:
Build strong and respectful partnerships with Indigenous communities, including Elders, leaders, and community members, to co-develop and implement culturally safe transport protocols.

Culturally Safe Practices During Transports:
Use culturally appropriate language and communication styles when interacting with Indigenous patients and their families.

Use a patient-centred approach that prioritizes the patient's preferences and needs, respecting their cultural beliefs and practice

Community-Based Programs:
Support and resource community-led initiatives that promote Indigenous health and well-being.

Feedback Mechanisms:
Establish clear and accessible mechanisms for Indigenous communities to provide feedback on the quality and cultural safety of transport services.

Pre-transport call evaluation

An appropriate and standardized pre-transport evaluation of a patient's clinical requirements improves patient safety during the transfer.

This assessment helps to confirm 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.

The **Individualized Transport Plan** developed in consultation with sending and receiving facilities, and BCEHS Transport Advisors assists in determining the level of patient care required for transport, but it is important to recognise that the patient's condition may change before the arrival of the transporting crew. A thorough bedside assessment must be conducted to ensure that the patient's condition aligns with the anticipated care documented within the transport plan.

All patients must be re-assessed by the BCEHS EMRs or paramedics prior to transport. If required, this should be done collaboratively with any medical escort and includes:

- a complete primary and secondary assessment.
- evaluation of baseline vitals.
- confirmation of infusions, medications, oxygen delivery, and monitoring requirements during transport.

Interfacility patient transport carries several risks including clinical deterioration, adverse events, and communication breakdowns. These risks can stem from the inherent challenges of moving patients between facilities, the potential for unforeseen complications during transit, and the need for specialized care and equipment.

Deterioration during transport:
Patients may experience clinical deterioration, such as hemodynamic instability, respiratory issues, or neurological changes, during transport.

Adverse events:
While most IFTs are uneventful, potential adverse events include equipment malfunctions, medication errors, or complications related to the patient's condition.

Increased risk for critically ill patients:
Patients with unstable conditions, those with pre-transfer risk scores, or those transferred by inexperienced medical escorts are at higher risk of deterioration.

Delays and complications:
Delays in transfer can be caused by various factors like aircraft refueling, waiting for escorts, or staffing issues.

Potential for errors:
There can be increased risk of errors with multiple handoffs and potential for duplication of testing.

Medical management principles for interfacility transport

Effective medical management during interfacility transport focuses on maintaining patient stability, preventing complications, and ensuring seamless handover to the receiving facility. This involves a systematic approach including pre-transfer preparation, continuous monitoring, appropriate interventions, and clear communication throughout the process.

BCEHS EMRs and paramedics are responsible for:

- ensuring clinical readiness and appropriate equipment is checked and functional in accordance with their scope of practice,
- reviewing transfer documentation and clarifying any concerns before departure,
- ensuring Intravenous lines, catheters and other supporting devices are secured, functioning and able to be maintained for the duration of the transport,
- confirming all medications are:
  - clearly labeled
  - accompanied by administration instructions
  - consistent with scope of practice or overseen by medical escort
- communication with the Transport Advisor to confirm the Individualized Transport Plan and discussing changes to the plan
- ensuring that an appropriate hand-over report is provided to the receiving facility upon arrival (Appendix A: Provincial Interfacility Handover Checklist)
- documentation of all assessments, interventions, and changes in patient condition during transport.

During an IFT, maintenance of therapy and medications may be a required.

Medications outside of the standard scope of practice of Primary and Advanced Care Paramedics may be continued during an IFT transport if specific criteria are met as follows:

- Management of the patient with the medication during the transport, (e.g., changing dose of medication to achieve or alter a therapeutic goal), exists within an **Individualized Transport Plan,** and
- Documentation from the sending physician clearly indicates the medication and dose to be administered within the **Individualized Transport Plan**, and
- The plan has been confirmed with a BCEHS medical practitioner.

Communication

Effective communication during interfacility transfers is crucial for ensuring patient safety and facilitating a smooth transition of care. It helps prevent errors, ensures the receiving facility is prepared, and allows for a coordinated response to any potential complications.

Accurate information transfer:
Clear and concise communication ensures that the receiving facility has all the necessary information about the patient's condition, medical history, and current treatment plan. This includes details about medications, allergies, and any special needs.

Preventing adverse events:
Inaccurate or incomplete information can lead to misdiagnosis, improper treatment, or even adverse events during the transfer or upon arrival at the receiving facility.

Preparedness of the receiving facility:
Effective communication allows the receiving facility to prepare for the patient's arrival, ensuring that necessary resources, such as staff, equipment, and medications, are readily available.

Coordination of care:
Clear communication facilitates a smooth transition of care, allowing the receiving team to seamlessly continue the patient's treatment and management.

Infection control:
Communicating about a patient's infectious or colonized status is critical to prevent the spread of infections to other patients and staff at the receiving facility.

Managing complications:
If complications arise during the transfer, clear communication between the ambulance crew and the receiving facility enables a coordinated response, potentially preventing serious adverse outcomes.

Reduced stress and anxiety:
For patients and their families, knowing that the transfer is well-coordinated and that the receiving team is informed can significantly reduce stress and anxiety associated with the transfer process. **When necessary, a BCEHS Indigenous Cultural Advisor should be consulted.**

Improved patient outcomes:
By facilitating accurate information transfer, proper preparation, and coordinated care, effective communication ultimately contributes to improved patient outcomes and a safer transfer experience.

When possible, significant changes in the patient's clinical condition that occur enroute should be communicated prior to arrival at the receiving facility. This will provide the receiving facility with an opportunity to prepare for any unanticipated clinical changes and allow for a safer handover and/or redirect to a different department within the facility.

Documentation

Documentation by EMRs and paramedics on interfacility transfers is important. Accurate and detailed records help receiving facilities understand the patient's condition, treatment, and any events during transport, enabling them to provide appropriate care upon arrival.

Continuity of Care:
Documentation serves as a vital communication tool between the sending and receiving facilities. It provides a clear picture of the patient's status, including vital signs, medications administered, and any changes in condition during transport, allowing for a seamless transition of care.

Legal Protection:
In the event of any legal issues or disputes, the documentation acts as the official record of the transfer, proving the patient's condition, treatment, and the events that occurred during transport. This is especially important in cases where patient care is challenged.

Clinical Significance:
Transfers can be complex and potentially risky, especially for critically ill patients. Thorough documentation helps identify and manage potential complications, ensuring the patient's safety and well-being throughout the transfer process. It allows for better allocation of resources and tailored treatment plans at the receiving facility.

Quality Improvement:
Analyzing documentation from multiple transfers can help identify areas for improvement in transfer protocols and procedures, ultimately leading to safer and more efficient patient care.

Standardization:
Using standardized documentation forms and procedures ensures consistency and clarity in the information being recorded, minimizing errors and misinterpretations.

Patient Safety:
Accurate documentation helps avoid delays and errors in care. By providing a clear picture of the patient's condition, it allows the receiving facility to prepare for and address any specific needs or potential complications, ensuring a safer transfer process.

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.

Components of an Individualized Transport Plan

An individualized transport plan is crucial for ensuring safe, accessible, and efficient transportation, especially for individuals with specific needs. It allows for tailored solutions that address unique requirements, promoting independence, community participation, and overall well-being.

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. Any change in the patient's clinical status may impact the plan for the destination facility.

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 providers with the appropriate **scope of practice** available to manage any unexpected events.

Considerations within the Individualized Transport Plan may include:

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 behavioural conditions, particularly those with a history of aggression or elopement risk, a comprehensive risk assessment should be conducted and treatment plan designed.
(see X02: Interfacility Transport of the Behaviourally Compromised Patient)

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.

Appendix A

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Provincial Interfacility Handover Checklist

This checklist is designed to help crews complete a safe hand-over when completing a IFT-whether that be a single journey between facilities, or when multiple crews are involved in a Newtons Cradle (A04) style event.

Transfer Details
- □ Sending facility name/unit & contact number
- □ Receiving facility name/unit & contact number
- □ Required documents sent or handed over
- □ Medication administration record
- □ ePCR Transferred successfully (and confirmed)
- □ Labs / imaging / ECGs
- □ MOST / ACP / DNR / other directives
- □ Family informed & transport mode clarified

Patient Identification
- □ Full name
- □ Date of birth
- □ PHN / ID number
- □ Allergies
- □ Language / communication needs

Medications & Treatments
- □ Medications administered in last 60 min
- □ Infusions (type, rate, pump?)
- □ Pain / sedation management
- □ Special equipment (e.g., pumps, monitors, restraints)

Clinical Status
- □ Primary diagnosis / reason for transfer
- □ Brief medical history / relevant comorbidities
- □ Vital signs at time of transfer (including NEWS2 if available)
- □ Infection control status (e.g., precautions, isolation required)
- □ Code status / MOST form present?
- □ Advance care planning / Goals of Care noted?

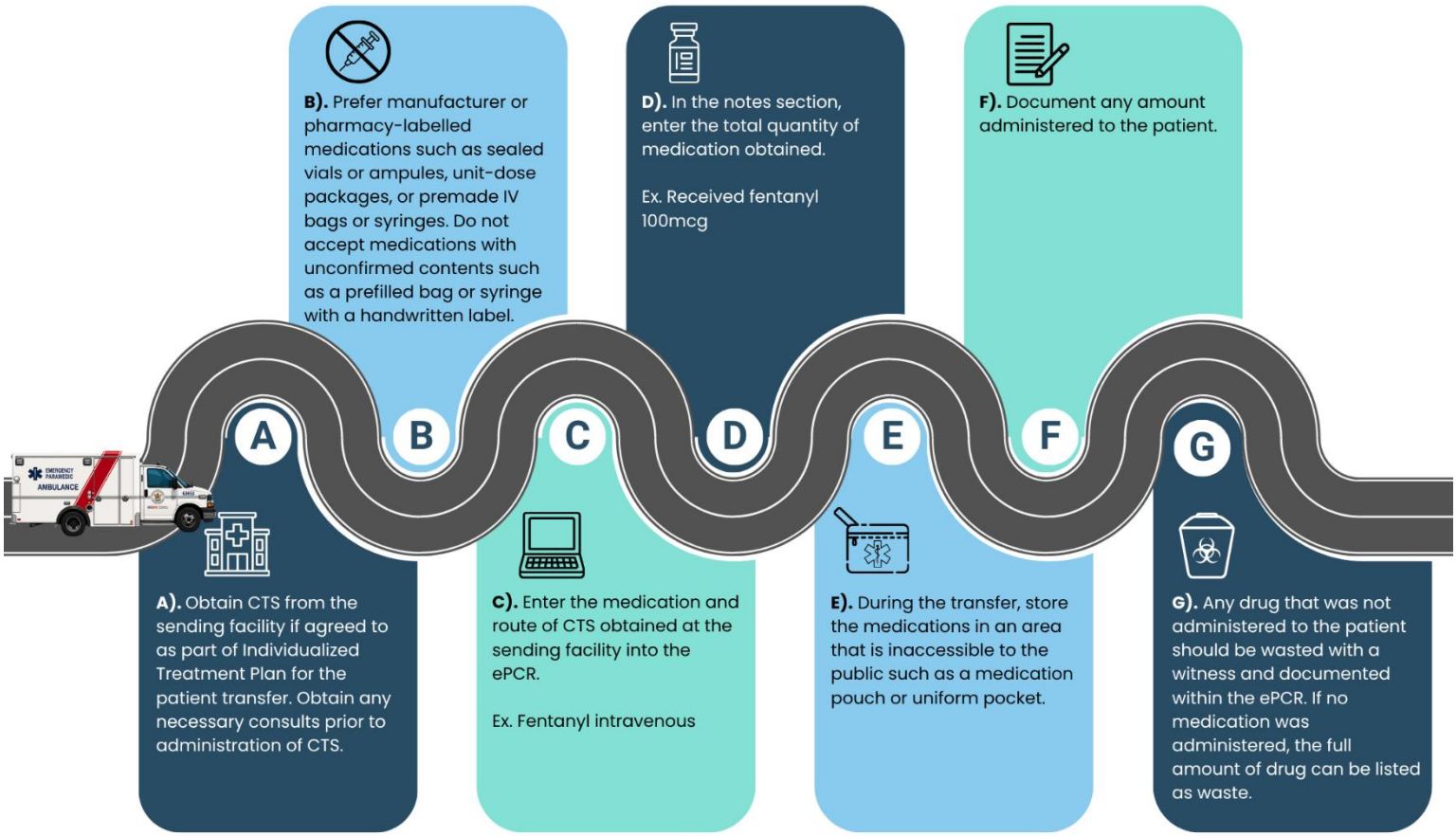
Ongoing Care Needs
- □ Airway: patent / adjuncts / oxygen required
- □ Breathing: baseline SpO_2 / respiratory support
- □ Circulation: IV access / infusions / bleeding risks
- □ Disability: GCS / sedation / neuro obs
- □ Exposure: wounds / drains / pressure areas

Concerns over patient identity?

When concerns arise over patient identification, whether inter-crew or at a sending facility– all BCEHS staff must speak up and raise these concerns to ensure a safe patient transfer. This is applicable to all clinical levels in the pre-hospital and interfacility transport environment.

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Appendix B



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Appendix C

Cardiac Monitoring – Primary Care Paramedic

Definition and Practice Expectations

Definition. Cardiac monitoring is the continuous or intermittent observation of a patient's cardiac activity using an approved cardiac monitor for the purpose of identifying changes in heart rate, regularity, monitor appearance, monitor alarms, or the patient's clinical condition that may indicate the need for reassessment, consultation, escalation of care, or modification of the transport plan.
Key principle: A PCP is expected to recognize change without requiring identification of a rhythm.

For Primary Care Paramedics (PCPs), cardiac monitoring supports ongoing patient surveillance and early recognition of clinical deterioration. It does not require the PCP to independently interpret or diagnose cardiac rhythms or ECG abnormalities, except for recognition of cardiac-arrest rhythms within the PCP scope of practice.

Cardiac Monitoring Includes

- Applying and maintaining ECG monitoring electrodes and cardiac monitoring equipment.
- Ensuring an adequate tracing is displayed and identifying or correcting common causes of artifact or poor signal quality.
- Observing the displayed heart rate and identifying significant changes in rate or apparent regularity.
- Recognizing that displayed cardiac activity has changed from an established baseline without requiring identification of the rhythm.
- Responding appropriately to cardiac monitor alarms and correlating monitor changes with the patient's clinical presentation.
- Reassessing the patient when a significant monitor change or alarm occurs, including pulse, blood pressure, level of consciousness, respiratory status, symptoms, and other relevant clinical findings.
- Obtaining, recording, or transmitting an ECG when indicated and within the practitioner's scope and authorization.
- Seeking clinical consultation, additional resources, or escalation of care when significant changes in cardiac activity or the patient's clinical condition are identified.

Cardiac-Arrest Rhythm Recognition

The distinction between cardiac monitoring and rhythm interpretation does not limit the PCP's responsibility to recognize and manage cardiac arrest. In the context of a clinical assessment confirming cardiac arrest, PCPs are expected to recognize and act on:

- Ventricular fibrillation (VF)
- Pulseless ventricular tachycardia (pVT)
- Asystole
- Pulseless electrical activity (PEA)

When VF, pulseless VT, asystole, or PEA is identified in a patient in cardiac arrest, the PCP should initiate or continue cardiac-arrest management in accordance with the applicable Clinical Practice Guideline and

scope of practice. This cardiac-arrest rhythm recognition does not extend to diagnostic interpretation of other cardiac rhythms or ECG abnormalities in patients with a pulse.

Cardiac Monitoring Does Not Mean Diagnostic Rhythm Analysis

- Identify or name a specific cardiac dysrhythmia outside of cardiac-arrest rhythm recognition.
- Independently interpret ECG morphology or diagnose an ECG abnormality.
- Make a diagnosis based solely on the appearance of the cardiac monitor.
- Rely upon an automated monitor interpretation as a clinical diagnosis.

Monitor alarms and automated monitor-generated interpretations are prompts for patient assessment, not diagnoses. The cardiac monitor is one component of the patient assessment and should be considered alongside the patient's pulse, vital signs, symptoms, and overall clinical presentation.

Examples

1. Change in rate and regularity – The patient's cardiac monitor has displayed a regular rate of approximately 75 beats/minute during transport. The monitor subsequently displays an irregular pattern with a rate of approximately 140 beats/minute and the patient reports dizziness and appears pale. The PCP is expected to recognize that a significant change has occurred, assess the patient, confirm the pulse and vital signs, evaluate for artifact or equipment issues as appropriate, and initiate consultation or escalation of care. The PCP is not required to identify or name the specific cardiac rhythm.

2. Monitor change without patient deterioration – The cardiac monitor alarm activates and the displayed cardiac activity appears different from the patient's previous tracing. The patient remains alert, has no new symptoms, and has a palpable pulse consistent with the previous assessment. The PCP should reassess the patient, check electrode placement and signal quality, consider artifact, review relevant vital signs, and continue appropriate monitoring. The alarm or change in monitor appearance does not, by itself, establish a cardiac diagnosis.

3. Automated interpretation – The cardiac monitor generates an automated message suggesting a particular rhythm or ECG abnormality. The automated interpretation should be treated as a prompt for further patient assessment and appropriate consultation, rather than as a diagnosis made by the PCP.

4. Deterioration to cardiac arrest – During transport, the cardiac monitor changes significantly and the patient becomes unresponsive. Assessment confirms that the patient is pulseless. The PCP should transition from routine cardiac monitoring to cardiac-arrest assessment and management. The PCP may identify whether the cardiac-arrest rhythm is VF, pulseless VT, asystole, or PEA and initiate treatment according to the applicable cardiac-arrest Clinical Practice Guideline.

Practice Principle

Patient with a pulse: Observe → Recognize change → Assess the patient → Escalate when indicated
Patient in cardiac arrest: Recognize a pulseless rhythm → Treat according to the applicable cardiac-arrest guideline

Cardiac monitoring means recognizing clinically relevant change without requiring identification of a rhythm and while maintaining the PCP's responsibility to act upon a pulseless rhythm in the context of cardiac arrest.