

## Section 1. Business Ethos and Processes

### 1. Business Ethos and Processes

#### 1.1. Business ethos

1.1.1. The service has a written mission statement.

1.1.2. The service clearly specifies its scope of care.

1.1.3. The service has a written code of ethical conduct that demonstrates ethical practices in business and marketing.

1.1.4. The service has a professional code of conduct for its employees.

1.1.5. The service audits its routine external providers of patient transport and care to ensure they offer the same level of ethical service.

1.1.6. The service shall compete fairly for all business opportunities and individual aeromedical transport missions.

1.1.7. The service shall not offer or solicit improper payments or gratuities in connection with obtaining a contract.

1.1.8. The service is properly directed and staffed according to the mission statement, anticipated individual needs, and scope of services offered.

1.1.9. The service has a clearly defined governance system and shall demonstrate its methods used to develop and maintain high standards.

1.1.10. The service operates an accredited management system such as ISO9001.

#### 1.2. Legal compliance

1.2.1. The service demonstrates compliance with the legal requirements and regulations of the government and local agencies under whose authority it operates.

1.2.2. The service complies with confidentiality and data protection laws in the areas in which it offers service cover.

1.2.3. The service ensures that its employees and those subcontracted to work on the behalf of the service shall maintain due confidentiality in respect of all third parties.

#### 1.3. Financial requirements

1.3.1. The service must declare its source(s) of funding and provide evidence of financial security.

1.3.2. The service must provide a description of the way the service is funded, supported by evidence from audited accounts.

1.3.3. There must be evidence in audited accounts to demonstrate that the service has sufficient financial reserves to sustain normal operations for at least three months.

1.3.4. Independent auditors must report on the business financials at the intervals required under corporation law in the service's base country.

#### **1.4. Insurance**

1.4.1. The service shall hold an appropriate level of insurance cover (according to the scale of the scope of its business) in the following areas:

1.4.1.1. Third party liability indemnity cover for the business.

1.4.1.2. Malpractice indemnity cover for health care professionals with limits of USD 3 million or above.

1.4.1.3. Health insurance, including injury and accident cover with death in service benefits.

1.4.1.4. Loss or damage of essential assets (such as medical equipment).

#### **1.5. Human resources**

1.5.1. There is a clear indication that service personnel are the most important factor for success, in that their motivation and education and training contribute decisively to meet high-level quality standards.

1.5.2. There shall be evidence that staff are valued and recognised for their contributions to the success of the service.

1.5.3. Staff shall receive feedback and appraisals at regular intervals.

1.5.4. Staff shall have a means of being kept informed about key HR issues, business policy and other management issues associated with their roles within the service.

1.5.5. There is a clear reporting mechanism to upper level management.

1.5.6. Staff members shall have a nominated manager with whom they can discuss concerns about the service, its procedures, safety, or any other issue, without fear of disadvantage, loss or other detriment.

1.5.7. There is a clear disciplinary process that protects employees from any unpredictable or capricious actions.

1.5.8. A business policy manual or 'handbook' is issued to all personnel.

#### **1.6. Management hierarchy**

1.6.1. There shall be a well-defined line of authority.

1.6.2. An organisational chart defines how the service fits into the corporate business and/or governing or sponsoring

1.6.2.1. The service should have a minimum of three departments:

1.6.2.1.1. Operations (which may include areas such as logistics, ticketing, and mission tracking).

1.6.2.1.2. Medical (which may include clinical services and medical support).

1.6.2.1.3. Business Support (to include all aspects of supporting the service)..

1.6.3. There shall be a policy that specifies the lines of communication and authority between the medical management team and the business team.
1.6.4. There shall be formal, periodic departmental and inter-departmental meetings for which minutes are kept.
1.6.5. Evidence shall demonstrate management encouragement for ongoing communication between commercial airline medical escorts and other personnel.
1.6.6. Evidence shall demonstrate that medical, logistic, safety and management information is disseminated between meetings to all staff via email, newsletter or other method of promulgation.
<b>1.7. Patient transport philosophy</b>
1.7.1. The service acknowledges that an appropriate transport should enhance the patient's outcome, whether this is a repatriation after discharge from medical care, a transfer to an increased level of medical care, or a transfer for palliative or social reasons.
1.7.2. Evidence shall demonstrate that all patient transfers from a lower level of care to an equal or higher level of care are supported by commercial airline medical escorts with the appropriate experience, skill sets and competencies for the higher level of care required by the patient.
1.7.3. Evidence shall demonstrate that quality patient care is not compromised by financial pressures.
1.7.4. Brokering of commercial airliner medical escort services runs the risk of loss of control of the quality of the service being provided. The company must adhere to the current EURAMI Standards on brokering for the specific services that it provides.
1.7.5. When the service uses another company by brokerage, evidence must be provided that the agent commissioning the mission, and the patient (or patient's next of kin/family), are made aware that the service is not using its own resources.
1.7.6. There shall be evidence that medical transport missions are planned and performed in the spirit of the 'bed to bed' concept, ie that, whenever practicable, aeromedical personnel escort their patients throughout the entire patient journey.
1.7.7. There shall be clear procedures for the exceptional use of tarmac transfers which interrupt the continuity of patient care by the service's escorting medical personnel.
1.7.8. Patient care treatment and monitoring must be provided continuously and without any disruption during the whole transport, and it should be comprehensively recorded in the transfer documentation.
<b>1.8. Marketing</b>
1.8.1. The commercial airliner medical escort service must use ethical and transparent marketing to ensure that potential clients and end users of the service are informed of:
1.8.1.1. Capabilities of the service.
1.8.1.2. Patients (defined by age group, level of care and specialty needs) considered appropriate for transport by the service.

1.8.1.3. Hours of operation, phone number, and access procedure.

1.8.2. Social media advertising shall be frequently scrutinised to ensure that no lapse of confidentiality or inappropriate entries appear online.

1.8.3. In its advertising, the service shall be completely honest and transparent when acting as a broker for the provision of commercial airliner medical escort services from external sources.

1.8.4. The senior management shall set guidelines for press related issues and marketing activities.

**1.9. Working environment**

1.9.1. The physical base of operations demonstrates an appropriate safe work environment for all personnel with adequate lighting, heating, ventilation, individual workspace, and storage of equipment for patient care and care of the transport aircraft and/or other vehicles.

1.9.2. Evidence must demonstrate compliance with health and safety legislation and regulations.

1.9.3. All patient care resources, including personnel and equipment; necessary to the service's mission must be readily available and operational prior to initiating a mission.

## Section 2. Safety and Quality Management

### 2. Safety and Quality Management

#### 2.1. Quality Control

2.1.1. The service shall have a quality manager (QM) who oversees all aspects of quality assessment and control across the complete range of services provided by the organisation. The QM may also take the role of safety manager (SM).

2.1.2. The service shall have a quality management committee that meets on a regular basis.

2.1.3. There is a clear trail of accountability for quality management in all areas of the service.

2.1.4. The service shall have a written policy defining the quality management system and its processes.

2.1.5. The quality policy is understood and followed at all levels and by all staff and each employee and/or subcontractor works towards measurable objectives.

2.1.6. The service shall have defined key performance indicators (KPIs) and quality targets (QTs).

2.1.7. Medical KPIs and QTs are based on clinical 'best-evidence' whenever possible, including international, national or local patient care guidelines or protocols, and supported by the service's own policies.

2.1.8. Mission KPIs and QTs are based on written logistics and operations guidelines, policies or protocols written by the commercial airliner medical escort service according to its mission statement, scope of service and capabilities.

2.1.9. The service shall produce regular quality control reports:

2.1.9.1. Annually, or

2.1.9.2. Six monthly

#### 2.2. Quality audit processes

2.2.1. The service shall have a quality management tools designed to collect, monitor and assess the activities and performance of the service continuously and in real time.

2.2.2. KPIs and QTs are designed to monitor patient care, operational efficiency, safety, and financial control.

2.2.3. KPIs and QTs are reviewed regularly:

2.2.3.1. Annually, or

2.2.3.2. Every two years

2.2.4. The quality system is regularly audited and evaluated for conformance and effectiveness.

2.2.5.Failure to meet KPIs and/or non-compliance to QTs are identified and highlighted by the Quality Manager or Quality Committee and corrective issues are addressed in a written action plan.

2.2.6.Action plans are audited, evaluated to ensure corrective action is being achieved, and re-evaluated for further action if KPIs and/or QTs are still not being met.

2.2.7. All action plans are reviewed on a regular basis and feedback is sent to relevant staff and management until the action plan is closed by the Quality Manager.

### **2.3. Quality audit processes review**

2.3.1.The regular quality management meetings are considered quorate when at least one representative from each of the relevant departments within the service is present (such as business, operations, and medical departments).

2.3.2.The periodic quality control reports are reviewed at senior management meetings.

2.3.3.Internal documents that form the basis for KPIs and QTs, such as patient care guidelines, policies, and protocols must be reviewed annually for currency, accuracy and appropriateness of the content.

### **2.4. Data used for quality control**

2.4.1. The service makes decisions about quality based on recorded data.

2.4.2. The service shall record the following quantitative (qn) and qualitative (ql) items:

2.4.2.1. Transport (qn)

2.4.2.1.1.Total number of transport missions.

2.4.2.1.2.Total transport time per mission.

2.4.2.1.3.Total mission time.

2.4.2.2.Classification of missions by flight medical escort (qn)

2.4.2.2.1.Total flights with single paramedic escort.

2.4.2.2.2.Total flights with single nurse escort.

2.4.2.2.3.Total flights with single doctor escort.

2.4.2.2.4.Total flights with two paramedic escorts.

2.4.2.2.5.Total flights with two nurse escorts.

2.4.2.2.6.Total flights with paramedic and nurse escorts.

2.4.2.2.7.Total flights with paramedic and doctor escorts.

2.4.2.2.8.Total flights with nurse and doctor escorts.

2.4.2.2.9.Total flights with paediatric ICU team.

2.4.2.2.10. Total flights with neonatal ICU team.

2.4.2.2.11. Total flights with psychiatric team.
2.4.2.2.12. Total flights with other specialist teams.
2.4.2.3. Classification of missions by medical (qn)
2.4.2.3.1. Total flights by primary diagnosis (parameters must be given).
2.4.2.3.2. Total flights by level of care.
2.4.2.3.3. Total flights by age group of patient.
2.4.2.3.4. Total flights by reason for the patient transfer (parameters must be given).
2.4.2.4. Clinical data (ql)
2.4.2.4.1. Medical adverse events during the mission (parameters must be given).
2.4.2.4.2. Clinical outcomes in case of adverse events (parameters must be given).
2.4.2.5. Performance feedback (qn and ql)
2.4.2.5.1. Total complaints reported and outcomes.
2.4.2.5.2. Total operations/logistics incidents reported and outcomes.
2.4.2.5.3. Patient and/or family satisfaction.
2.4.2.5.4. Commissioning agent/person satisfaction.
<b>2.5. Safety management</b>
2.5.1. Safety management system (SMS)
2.5.1.1. The service shall have a safety manager (SM) who oversees all aspects of safety across the complete range of services provided by the organisation. The SM may also have the role of quality manager (QM).
2.5.1.2. The service has adopted a culture of safety that is recognised and followed in by its staff.
2.5.1.3. The service shall have a written policy defining the SMS and its processes.
2.5.1.4. The safety management system is understood and followed at all levels and by all staff and/or subcontractors.
2.5.1.5. The service has a safety management system (SMS) that provides a systematic way to identify hazards and control risks while maintaining assurance that these risk controls are effective.
2.5.2. Safety committee
2.5.2.1. The safety committee must comprise of at least one representative from each of the arms of the service (business, operations and medical).
2.5.2.2. The committee shall meet regularly to discuss risks, actual occurrences and actions following previous reports.
2.5.2.3. Committee meetings shall be held at least monthly.

2.5.2.4. Written reports on the activities of, and decisions made by, the safety committee shall be submitted to senior management meetings.

2.5.2.5. Recommendations for amendments to operational and safety issues must be reviewed by senior management.

### 2.5.3. Safety reporting

2.5.3.1. The service encourages all staff to complete safety deficiency reports on any occasion that a hazard or potential hazard is encountered.

2.5.3.2. Safety reports are dispatched to the Safety Manager (or nominated deputy) as soon as possible after the occurrence/incident so that remedial action can be expedited.

2.5.3.3. The Safety Manager has authority to escalate safety reports to senior management at any time.

2.5.3.4. All action plans are reviewed on a regular basis and feedback is sent to relevant staff and management until the action plan is closed by the Safety Manager or senior management.

## 2.6. Risk management

2.6.1. The SMS is linked with risk control/management, so that concerns raised through the risk management process can be followed up through the continuous quality control program.

2.6.2. The service operates a risk control process that:

2.6.2.1. Allows identification of hazards and risks.

2.6.2.2. Assesses the worst case impact of individual hazard, should they occur.

2.6.2.3. Assigns a likelihood of each risk actually occurring

2.6.2.4. Proposes risk management strategies designed to eliminate, ameliorate or mitigate either the hazard itself, or the consequences of the hazard.



## Section 3. Mission Operations

### 3. Mission Operations

#### 3.1. Operations

3.1.1. The logistic management and handling of medical staff, and all the support needed to successfully complete a commercial airline medical escort service is undertaken by an operations department.

3.1.2. The functions of the operations department are subdivided in to:

3.1.2.1. Logistics.

3.1.2.2. Medical Operations.

3.1.3. The operations department contains a communications centre responsible for:

3.1.3.1. Receiving calls from clients and commissioners of CAME transfers.

3.1.3.2. Sending and receiving patient medical reports.

3.1.3.3. Tracking mission progress (flight following).

#### 3.2. Communications

3.2.1. There is a communications policy and/or procedures manual.

3.2.2. The communications centre is available 24 hours a day all year round.

3.2.3. There is at least one dedicated phone line for mission co-ordination.

3.2.4. There is at least one dedicated email and mobile phone number for mission communications.

3.2.5. Staff are aware that noise and other distractions must be minimised in the communications area while personnel are involved with a medical transport mission.

3.2.6. All incoming and outgoing phone calls are recorded (if national laws permit).

3.2.7. All parties are informed that their conversation is recorded as per national data protection regulations (if 3.2.6. is relevant).

3.2.8. Recordings are time stamped and may be played back directly by communications personnel.

3.2.9. There is an electronic case management software tool. This tool shall be used to gather medical, logistics, and transport data centrally.

3.2.10. There is a real or virtual status board with information about:

3.2.10.1. Booked flights.

3.2.10.2. Current flights (missions in progress).

3.2.10.3. Flight medical crew on duty and standby (availability).
3.2.11. In case of loss of mains power to the communication equipment there is either:
3.2.11.1. Back-up emergency power source for communications equipment.
3.2.11.2. Policy and system for maintaining communications by other means.
<b>3.3. Operations personnel</b>
3.3.1. An Operations Manager shall be employed to control and manage the daily activities of the operations department(s).
3.3.2. There shall be adequate personnel to provide full coverage of all operations activities using a staff rota that enables 24 hour cover all year round.
3.3.3. Shall have a full command of the official languages of the country in which the commercial airliner medical escort service is based, as well as of English if the service is not based in an English-speaking country.
3.3.4. Training of operations personnel shall include:
3.3.4.1. Use of the service's case management IT system.
3.3.4.2. Financial aspects of quoting and estimating missions.
3.3.4.3. Geographical limits and other considerations applicable to the service.
3.3.4.4. Border control regulations (immigration and customs).
3.3.4.5. Company Operations Manual.
3.3.4.6. Company safety regulations and emergency procedures.
3.3.4.7. Dangerous Air Cargo (DAG) regulations and procedures, in as much as includes batteries, medicines, and other items that may be used for a CAME mission.
3.3.4.8. Safety Management System (SMS).
3.3.4.9. Mission logistics planning.
3.3.4.10. Flight following (tracking) procedures.
3.3.4.11. Completion and submission of MEDIFs (medical information forms) to airline offices.
3.3.4.12. Major incident co-ordination.
3.3.4.13. The capabilities and resources of airports, ground ambulance suppliers, receiving hospitals and other facilities that are needed for a successful mission outcome.
3.3.5. Duties of operations personnel shall include:
3.3.5.1. Central co-ordination for communications between external individuals and agencies, and between departments within the operational arm of the service, in all aspects related to the safe and efficient undertaking of a mission.
3.3.5.2. Issue quotes and/or estimates for missions when requested by outside agencies.

3.3.5.3.	Receive and co-ordinate requests for patient transports.
3.3.5.4.	Assignment of crew according to rotas which conform with national regulations.
3.3.5.5.	Set up logistic stages of each sector in the mission plan.
3.3.5.6.	Access to medical personnel visas and passport information in order to complete flight ticketing documentation.
3.3.5.7.	Continuous flight following (mission tracking) shall be routine, and the following data collected for audit purposes.
3.3.5.7.1.	Pre-take-off
3.3.5.7.1.1.	Date and time (with time-zone) when initial request is received.
3.3.5.7.1.2.	Name and phone number of requestor and the commissioning organisation or individual.
3.3.5.7.1.3.	Patient name, age, date of birth and gender.
3.3.5.7.1.4.	Diagnosis and/or reason for transfer.
3.3.5.7.1.5.	Referring and receiving medical team details.
3.3.5.7.1.6.	Referring and receiving facilities details.
3.3.5.7.1.7.	Whenever possible, confirmation of bed availability and acceptance by receiving physician and
3.3.5.7.1.8.	Departure airport.
3.3.5.7.1.9.	Destination airport.
3.3.5.7.1.10.	Stopovers, if applicable.
3.3.5.7.1.11.	Ground transportation service details at sending area.
3.3.5.7.1.12.	Ground transportation service details at receiving area.
3.3.5.7.2.	Transfer
3.3.5.7.2.1.	Time of departure from base.
3.3.5.7.2.2.	Flight medical escort details.
3.3.5.7.2.3.	Estimated time of arrival at destination (if applicable).
3.3.5.7.2.4.	Pertinent airport information.
3.3.5.7.2.5.	Time of arrival at patient collection facility.
3.3.5.7.2.6.	Time of departure from patient collection facility.
3.3.5.7.2.7.	Time of arrival at patient receiving facility.
3.3.5.7.2.8.	Time departure from patient receiving facility.
3.3.5.7.2.9.	Time arrival at base.
3.3.5.7.2.10.	Time of end of mission.
3.3.5.7.3.	If mission cancelled

3.3.5.7.3.1.	Time mission is aborted or cancelled after dispatch.
3.3.5.7.3.2.	Reason for cancellation of flight.
<b>3.4. Use of operations data</b>	
3.4.1.	The service demonstrates that the security of the data collected meets the high standards required for national data protection/confidentiality laws.
3.4.2.	The service demonstrates that the data is accurate and complete.
3.4.3.	The service provides evidence that these data are used to improve the quality, safety, efficacy and efficiency of the service.
3.4.4.	The commercial airliner medical escort service provides evidence that the findings and conclusions of the audited data are promulgated to:
3.4.4.1.	Key players within the service's own operations.
3.4.4.2.	External publication for the benefits of the wider aeromedical community.
<b>3.5. Incident plan</b>	
3.5.1.	The service must have a readily accessible incident plan in the event or suspicion of a serious occurrence and/or when anticipated communication with the aeromedical escort cannot be established or verified.
3.5.2.	The plan shall include
3.5.2.1.	List of personnel/telephone numbers to notify as well as their priority to activate in the event of an accident or incident.
3.5.2.2.	Guidelines to follow in attempts to communicate with the airline(s).
3.5.2.3.	Communications policies to ensure accurate information dissemination.
3.5.2.4.	Procedures to secure all documents, and recordings related to the particular incident.
3.5.2.5.	Procedure to deal with releasing information to the press.
3.5.3.	An annual exercise is conducted to test the post incident plan. This exercise should involve flight medical escorts, operations personnel, ground staff and management staff.

## Section 4. Medical Management

### 4. Medical Management

#### 4.1. Medical department overview

4.1.1. The service has a dedicated and integrated medical department, the structure of which is described using one or more hierarchy charts. The charts show the following details of the medical management structure:

4.1.1.1. The relationship of the medical department within the structure of the company and its key executives.

4.1.1.2. The relationship between the medical department and other key areas which impinge on the operational capability of the service.

4.1.1.3. All medical personnel shall understand the medical department management hierarchy ('chain of command').

#### 4.1.2. Department documentation

4.1.2.1. Management ensures that patient care records, meeting minutes, policies and procedures are stored according to the service's policy and are indicative of the service's sensitivity to patient confidentiality.

4.1.2.2. A copy of the patient care record remains at the receiving facility for appropriate continuity of care.

4.1.2.3. Standard operating procedures and policies define what treatment may be performed without direct medical supervision and in which situations.

4.1.2.4. Policies are dated and signed by at least two appropriate managers.

4.1.2.5. Policies are reviewed on an annual basis as verified by at least two managers' signatures on a cover sheet or on respective policies.

4.1.3. The medical department of the service employs appropriately qualified and experienced personnel in key office-based appointments. The following list is recommended, but individual services may utilise their staff in different ways to cover the recommended roles:

4.1.3.1. Medical Director (may be called 'Chief Medical Officer', 'Senior Flight Physician' or such other term as is preferred by the CAME service).

4.1.3.2. Clinical Manager, which may be:

4.1.3.2.1. If appropriate to the service: Flight Nurse Manager (may be called Senior Flight Nurse, Chief Nurse, etc.).

4.1.3.2.2. If appropriate to the service: Flight Paramedic Manager (may be called Senior Flight Paramedic, Chief Paramedic, etc.).

4.1.3.2.3. If appropriate to the service: Flight Nurse Co-ordinator(s) (may be called Flight Nurse Ops, Office Flight Nurse, etc.).
4.1.3.2.4. If appropriate to the service: Flight Medical Operations Co-ordinator(s) (may be called Medical Ops Manager, etc).
4.1.4. The medical department of the service employs appropriately qualified and experienced personnel (as defined below) in the following flying full-time, part-time, or mission-specific contracted appointments:
4.1.4.1. If appropriate to the service: Flight Doctors.
4.1.4.2. If appropriate to the service: Flight Nurses.
4.1.4.3. If appropriate to the service: Flight Paramedics.
4.1.4.4. If appropriate to the service: Other non-physician health care professionals.
4.1.4.5. If appropriate to the service: Expert medical personnel key to any specialist aspects of the CAME service (e.g. neonatal care, psychiatric care).
<b>4.2. Human resources</b>
4.2.1. There must be adequate personnel to provide full coverage of all clinical activities using flight nurses, flight physicians, or other health care professionals who are assigned to the service and are readily available within the response time determined by the service.
4.2.2. All flight medical crew must be licensed, registered, certified or permitted according to the national regulations of the country in which the service is based, and, on recruitment, must meet minimum educational requirements specific to the mission statement and scope of service and set by the company.
4.2.3. Flight medical escort scheduling must demonstrate strategies to minimise duty time fatigue, including such strategies as planning of crew constitution, rest periods, management of jet lag and time on shift, length of shifts per week and day-to-night rotation, according to any flight time limitations or working-time laws or regulations required in the country in which the service is based.
4.2.4. Currency shall be ensured and documented by way of a flight/mission log book, which must be kept up-to-date by both the individual crew member and also by the management of the service.
4.2.5. Training programs are planned and structured to include both initial (induction/introduction) education, as well as ongoing (continuation) training.
4.2.6. Training is available to all flight medical personnel and is guided by the mission statement and scope of care of the service.
<b>4.3. Standards for medical personnel</b>

4.3.1. Training is mapped against aeromedical competency requirements as clearly defined by the Medical Director.
4.3.2. Successful completion of the educational components specified by the training program are documented for each member of the flight medical personnel.
4.3.3. Each individual member of the medical department, whether permanent or non-permanent (subcontracted) staff, is appraised at a regular assessment/evaluation meeting by one or more senior medical managers, during which their training record and mission logbook are checked to ensure the established minimum standards of the service are upheld.
4.3.4. Evidence should demonstrate that routine appraisals for each individual member of the medical department are staged at regular intervals.
4.3.5. Evidence should demonstrate that extraordinary appraisals are performed in exceptional circumstances, such as following critical incidents or to evaluate performance considered to be either well below what is considered safe, or when performance is exceptionally good and considered worthy of tribute.
4.3.6. The service has occupational health policies. These address the following topics:
4.3.6.1. Pre-employment and physical examination or medical screenings, as well as immunisation history.
4.3.6.2. The recruitment or ongoing employment of flight medical personnel with a psychiatric history.
4.3.6.3. Dress codes and the use of protective clothing pertinent to the mission profile and safety procedures of the CAME service.
4.3.6.4. Crew duty time limitations for flight medical personnel that addresses the issues of fatigue, performance, maximum duty time and advice with regards to adequate rest.
4.3.6.5. Hearing protection on the ground and in the air as needed.
4.3.6.6. Duty status during pregnancy.
4.3.6.7. Duty status during acute illnesses.
4.3.6.8. Duty status while taking any chronic medication.
4.3.6.9. Duty status after diving.
4.3.6.10. Manual handling (lifting and loading).
4.3.6.11. Drugs and alcohol abuse policy.
<b>4.4. Medical training</b>
4.4.1. The service holds current and historical evidence of planned and structured training programs including attendance records of all flight medical personnel employed or contracted by the service.
4.4.2. Performance of each flight medical crew person at each training session is measured against a set of minimum standards of competency and currency, as established by the Medical Director and based on the Mission statement and scope of the service.

4.4.3. Individuals' performance in training is documented in a training record that includes a minimum of a two part induction training program for new recruits to the service, and a continuing education program for all personnel, as well as a personnel appraisal system.

4.4.4. The following list of subjects is covered in Part 1 of the induction training program:

4.4.4.1. The flight environment.

4.4.4.2. Altitude physiology.

4.4.4.3. Biodynamics of movement.

4.4.4.4. Limitations of in-flight management of patients.

4.4.4.5. Clinical considerations in the transport of specific adult patients:

4.4.4.5.1. Respiratory.

4.4.4.5.2. Cardiac/cardiovascular/haematological.

4.4.4.5.3. Neurologic/neurosurgical.

4.4.4.5.4. Orthopaedic/spinal.

4.4.4.5.5. Otorhinolaryngeal/maxilla-facial/ophthalmic.

4.4.4.5.6. Environmental injuries.

4.4.4.5.7. Major and/or multiple trauma.

4.4.4.5.8. Burns.

4.4.4.5.9. Post-surgical.

4.4.4.5.10. Intensive care patients.

4.4.4.6. Advanced cardiac life support.

4.4.4.7. Human factors and CRM (crew resource management).

4.4.5. The following list of subjects is covered in Part 2 of the induction training program:

4.4.5.1. Introduction to the service:

4.4.5.1.1. Introduction to the philosophy, capabilities and structure of the service.

4.4.5.1.2. Overview of the operations of a complete repatriation, retrieval and/or transfer mission.

4.4.5.1.3. Overview and summary of company policies, procedures and guidelines, with information on how to access and use them.

4.4.5.1.4. The relationship between travel insurance, medical assistance and flight medical personnel.

4.4.5.2. Essentials for successful mission completion:

4.4.5.2.1. Essential procedures for flight medical personnel pre-, intra-, and post-mission.



4.4.5.2.2. Familiarisation and competency using the service's medical equipment.
4.4.5.2.3. Infection control philosophy and procedures.
4.4.5.2.4. Commercial airline essential knowledge.
4.4.5.3. Personal health and safety.
4.4.5.3.1. Aircraft emergency procedures.
4.4.5.3.2. Occupational health, fitness to fly and stress management.
4.4.5.4. Clinical governance.
4.4.5.4.1. Aeromedical risk analysis and management.
4.4.5.4.2. Quality management and audit systems.
4.4.6. There is a planned and structured continuing professional development (CPD) program which provides continuation training at least twice a year.
4.4.7. All of the topics addressed in the induction program are reviewed and updated over a rolling two year CPD program.
4.4.8. The CPD program includes case-related clinical governance sessions which provide a forum for discussing the successes as well as the problems encountered during recent missions.
<b>4.5. Medical personnel</b>
4.5.1. Medical Director
4.5.1.1. The service employs a Medical Director (may be called 'Chief Medical Officer', 'Senior Flight Physician' or such other term as is preferred by the CAME service) who is available for consultation within normal day-time working hours.
4.5.1.2. Where a Medical Director works only part-time for the service, one or more nominated deputies share the on-call availability rota as long as other members of the medical department are aware of who has overall responsibility at all times.
4.5.1.3. Where a Medical Director is a consultant advisor who works outside of the company, the company must provide evidence that all the roles of the Medical Director are being fully and appropriately covered by personnel qualified to do so.
4.5.1.4. The Medical Director is responsible for the establishment and maintenance of the highest quality of medical care provided by its flight medical personnel.
4.5.1.5. The service must provide a resume (CV) of the Medical Director(s) and supporting documentation which demonstrate the following criteria:
4.5.1.5.1. An unrestricted license to practice and professional registration in the country in which the service is based.
4.5.1.5.2. More than four years of relevant clinical experience, and senior (higher) qualifications in intensive care medicine, anaesthesia, or emergency medicine.
4.5.1.5.3. A minimum of 2 years' experience in a critical care or emergency medicine environment.

4.5.1.5.4.	Maintain clinical currency in an acute medical role on a weekly or monthly basis.
4.5.1.5.5.	Full command of the official languages of the country in which the CAME service is based.
4.5.1.5.6.	A good working knowledge of the English language if the service is operating internationally.
4.5.1.5.7.	Received postgraduate training and qualification in patient transport which is accredited or otherwise recognised by a national or international academic body, such as university, health board, professional accrediting board or college, or other acknowledged and acclaimed education provider.
4.5.1.5.8.	A thorough understanding of the general concepts of safe and efficient utilisation of aeromedical and ground resources.
4.5.1.5.9.	The Medical Director demonstrates sufficient expertise and currency pertinent to the mission statement and scope of care of the service and according to international standards.
4.5.1.5.10.	The Medical Director demonstrates sound clinical and logistic decisions affecting medical care provided by the whole service.
4.5.1.5.11.	The Medical Director demonstrates personal high standards of care for all patients, but especially those who are critically ill or injured.
4.5.1.5.12.	The Medical Director has related areas of responsibility which include:
4.5.1.5.12.1.	Overall management and direction of recruiting, training and continuing education for all health care professionals in the service.
4.5.1.5.12.2.	Ensuring the competency and currency of all medical personnel working with the service.
4.5.1.5.12.3.	The development and maintenance of guidelines concerning diseases and injuries that require specific management or medical control input during patient transport.
4.5.1.5.12.4.	Ensuring timely review of patient care, utilising audit tools and patient transport documentation, with the guidance of pre-established criteria.
4.5.1.5.12.5.	Development and maintenance of processes to identify, document and analyse adverse medical events or potential adverse events with the specific goal of improving patient safety and quality of
4.5.1.5.12.6.	Overview of the quality management (QM) program.
4.5.2.	Clinical manager
4.5.2.1.	The service employs a clinical manager, who may be a Flight Nurse Manager (otherwise known as 'Chief Flight Nurse', 'Senior Flight Nurse' or such other term as preferred by the CAME service) or other health care professional of similar
4.5.2.2.	The clinical manager shall have experience in both air and ground patient transport apposite to the mission statement and scope of service. The includes responsibility or oversight of the following:

4.5.2.2.1.	Day-to-day overview of office management in the medical department.
4.5.2.2.2.	Daily 'ward round' of current ongoing and planned cases, with clear communications between the Medical Director and others in the medical department.
4.5.2.2.3.	Interface with Medical Operations and Flight Operations.
4.5.2.2.4.	Clinical case management.
4.5.2.2.5.	Initial screening of completed case documentation, identification of issues for follow-up and reporting to the Medical Director.
4.5.2.2.6.	Human resources issues.
4.5.2.2.6.1.	Recruiting, interviewing, training records, currency and competency status.
4.5.2.2.6.2.	Maintenance of rotas, availability calendar, and key operability status board(s).
4.5.2.2.7.	Stock management and procurement of:
4.5.2.2.7.1.	Pharmacy items.
4.5.2.2.7.2.	Medical equipment.
4.5.2.2.7.3.	Medical consumables.
4.5.2.2.7.4.	Medical gases.
4.5.2.2.8.	Refurbishment of medical equipment and pharmacy bags/stores after each mission.
4.5.2.2.9.	Organisation of external contracts for service requirements, including:
4.5.2.2.9.1.	Routine cleaning and infection control.
4.5.2.2.9.2.	Waste and sharps disposal.
4.5.2.2.9.3.	Maintenance of medical equipment servicing.
4.5.2.2.9.4.	Resupply, filling and maintenance of medical gas supplies.
4.5.2.3.	Other roles of the clinical manager may be shared with the Medical Director, and may include:
4.5.2.3.1.	Validation of the service's medical policies and guidelines.
4.5.2.3.2.	Recruitment, training and continual education of all non-physician medical personnel.
4.5.2.3.3.	Administrative decisions regarding patient care.
4.5.2.3.4.	Daily assignment of flight medical personnel to individual missions.
4.5.2.3.5.	Active involvement in the quality management program.
4.5.2.3.6.	Provision and promulgation of mission briefing notes covering all relevant personal, clinical and logistic
4.5.3.	Service coordinator

4.5.3.1. If the service employs one or more Flight Nurse (or other health care professional) Coordinators (may be called 'Flight Nurse Ops', 'Office Flight Nurse' or such other term as preferred by the service ), the coordinator shall have experience in both air and ground patient transport apposite to the mission statement and scope of service.

4.5.3.2. The responsibilities for this role include:

4.5.3.2.1. Deputising for all the roles of the clinical manager.

4.5.3.2.2. Provision of day-to-day continuity of case management with clear, concise and accurate handover of clinical and logistic information between shifts.

4.5.3.2.3. Day to day interface with Medical and Operations personnel.

4.5.3.2.4. Daily refurbishment of medical consumables and equipment.

#### 4.5.4. Flight Doctors

4.5.4.1. If the service employs its own Flight Doctors (also known as Flight Physicians). Every flight physician employed by the service, both full and part-time, shall comply with the following criteria:

4.5.4.1.1. Possesses a license to practice and is professionally registered in the country in which the service is

4.5.4.1.2. Has at least two years of relevant clinical experience, in either anaesthesia, intensive care medicine, or emergency medicine.

4.5.4.1.3. (If undertaking critical care transfers) – Has at least 12 months experience in a critical care environment.

4.5.4.1.4. Maintains clinical currency in an acute medical role on a weekly or monthly basis.

4.5.4.1.5. Has full command of the official language of the country in which the service is based.

4.5.4.1.6. Has a good working knowledge of the English language if the service is operating internationally.

4.5.4.1.7. Continuing education is provided and documented for flight doctors and is specific and pertinent to the mission statement and scope of care of the service.

#### 4.5.5. Other non-physician health care professionals

4.5.5.1. The service may employ Flight Nurses for routine in-flight care during patient transport. If so, each Flight Nurse must meet the essential national regulatory criteria for employment as a qualified and registered nurse, as well as any criteria set by the Medical Director of the service.

4.5.5.2. The service may employ Flight Paramedics for routine in-flight care during patient transport. If so, each Flight Paramedic must meet the essential national regulatory criteria for employment as a qualified and registered paramedic, as well as any criteria set by the Medical Director of the service.

4.5.5.3. The service may employ Flight Respiratory Therapists for routine in-flight care during patient transport. If so, each Flight RT must meet the essential national regulatory criteria for employment as a qualified and registered RT, as well as any criteria set by the Medical Director of the service.
4.5.5.4. The service may employ other categories of health care professionals for routine in-flight care during patient transport as long as there is a clear clinical requirement, all national, local and company criteria are met, and there is evidence of supervision by the Medical Director and/or other physicians working for the service.
4.5.5.5. The service must have evidence of a clear legal framework to support the use of non-physician/non-nurse personnel for the interhospital transfer of critically ill or injured patients.
4.5.5.6. The service must demonstrate the means by which non-physician/non-nurse personnel may be legally utilised as flight medical crew in countries where similar groups of allied health care professionals do not exist or where they do not share the same privileges of practice.
4.5.5.7. The service must provide evidence of current corporate and/or individual professional indemnity insurance for the use of non-physician/non-nurse personnel in the interhospital transfer role.
4.5.5.8. Each individual is licensed to practice and is professionally registered in the country in which the service is based.
4.5.5.9. Only personnel who are deemed by the Medical Director to have the necessary training, qualifications, knowledge, experience and competency are employed to undertake such missions.
4.5.5.10. Non-physician/non-nurse flight medical personnel receive the same initial induction training, with didactic operational and clinical components as offered to the doctor and nurse flight medical crew.
4.5.5.11. Non-physician/non-nurse flight medical personnel receive the same ongoing regular education programs with didactic operational and clinical components as offered to the doctor and nurse flight medical crew.
4.5.5.12. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director.
4.5.5.13. The service must provide evidence of the means by which non-physician/non-nurse personnel are supervised both on-line and off-line.
4.5.6. Specialist Personnel
4.5.6.1. Specialist personnel may be employed or sub-contracted for neonatal, paediatric, advanced critical care transfers, or other highly specialised areas of clinical practice.
4.5.6.2. When these specialists are not part of the company's core team of flight medical personnel (i.e. they are added to supplement the service's own employed flight medical personnel), they are obliged to meet the following requirements:

4.5.6.2.1. Compliance with national licence, registration and/or certification requirements of the country in which the service is based.

4.5.6.2.2. Recognised relevant specialist knowledge, experience and currency, as defined by the requirements of the mission and established by the Medical Director.

4.5.6.3. When the specialists are part of the service's core team of flight medical crew, they must receive an abbreviated specific induction training, designed to introduce 'medical passengers' or 'temporary flight medical crew members' to the service. This training covers the topics considered essential for a successful, safe and efficient outcome to the mission which include the following minimal set:

4.5.6.3.1. Flight environment.

4.5.6.3.2. Altitude physiology.

4.5.6.3.3. Biodynamics of movement.

4.5.6.3.4. In-flight management of patients.

4.5.6.3.5. Aircraft safety.

4.5.6.3.6. Emergency procedures.

4.5.6.4. Continuing education is offered to specialist care professionals with an interest in continuing their service. The training is specific and pertinent for the mission statement, scope of care of the service and the specialist's role within the service.

## Section 5. Clinical Practice

### 5. Clinical Practice

#### 5.1. Scope of service

5.1.1. The service has a written mission statement and a document which details the scope of the service.

5.1.2. There is evidence that staff are completely cognisant of with the mission statement and scope of care of the service.

5.1.3. The service has documented criteria with regards to the provision of appropriate care required by patients requiring aeromedical transport. This shall include:

5.1.3.1.1. A description of the levels of care of patients that can be transported.

5.1.3.1.2. Associated types and numbers of health care professionals that are required for each level of care.

5.1.3.1.3. The minimum equipment set(s) that must be carried for each level of care.

#### 5.2. Medical resources

##### 5.2.1. Medicines Management

5.2.1.1. The service must demonstrate compliance with national medicines management laws, regulations and procedures. The following information must be provided:

5.2.1.1.1. Details of an accountable person, chosen from the senior management in the medical staff, who has overall responsibility for pharmacy management.

5.2.1.1.2. Details of persons or personnel roles that have access to pharmacy stores.

5.2.1.1.3. Demonstration of a pharmacy room or store cupboard which complies with the security demands of the national regulatory body. At a minimum, the service must have a locked cupboard within another locked cupboard or room.

5.2.1.1.4. Evidence of compliance with national laws, regulations and recommendations for the storage, carriage, supply and use of controlled drugs.

5.2.1.1.5. Evidence of compliance with national and/or international recommendations for the storage, carriage, supply and use of refrigerated drugs.

5.2.1.1.6. There must be a system to ensure that expiration dates of medications and other consumables are checked regularly.

5.2.1.1.7. Evidence of accurate and precise stock checking and procurement of medicines.

5.2.1.1.8. Evidence of medicines wasted, destroyed or returned.

5.2.1.1.9. Examples of patient-specific directions which authorise non-physicians to dispense medicines with off-line supervision (under the guidance of national, international or local regulations).
5.2.1.1.10. Examples of generic directions which authorise non-physicians to dispense medicines with off-line supervision (under the guidance of national, international or local regulations).
5.2.1.1.11. Evidence of the licence or permissions needed under national and/or local regulations, where they exist, to import or export medicines.
5.2.1.1.12. Evidence for the thorough checking and refurbishing of medical equipment bags to ensure all pharmacy items are in place and in-date.
5.2.2. Medical Gases Management
5.2.2.1. If the company provides oxygen cylinders on airlines that accept external cylinders, evidence must be provided to demonstrate compliance with national and/or local regulations and recommendations concerning medical gases. The following information must be provided:
5.2.2.1.1. Details of an accountable person, chosen from the medical staff, who has overall responsibility for medical gases management.
5.2.2.1.2. Evidence of compliance with national laws, regulations and recommendations for the procedures of storage, carriage, supply and use of medical gases.
5.2.2.1.3. Demonstration of a medical gases storage facility which complies with national health and safety recommendations. At a minimum, this will be provision for a lockable cylinder store within a secure area.
5.2.2.1.4. Evidence of clearly marked separation of full and used cylinders in the storage area.
5.2.2.1.5. Evidence of accurate and precise stock checking and procurement of medical gas cylinders, and also of timely servicing or replacement of the cylinders.
5.2.2.1.6. Evidence of regular inspection and certification of in-flight oxygen cylinders.
5.2.2.2. Instructions to flight medical personnel on the following:
5.2.2.2.1. Understanding the benefits and hazards of supplemental oxygen in flight.
5.2.2.2.2. National and international cylinder specifications and differences.
5.2.2.2.3. Safe storage and use of portable oxygen cylinders in flight and on the ground.
5.2.2.2.4. Calculation of patient-specific oxygen and medical air requirements.
5.2.2.2.5. Safe and efficient use of oxygen flow regulators and delivery devices.
5.2.3. Medical Equipment Management



5.2.3.1. The service must provide details of the accountable person who has day-to-day responsibility for medical equipment management.
5.2.3.2. The service must provide a list of all major items of medical equipment and evidence of:
5.2.3.2.1. The make and model of each item.
5.2.3.2.2. Procurement, purchase or rental agreement.
5.2.3.2.3. Equipment is periodically tested and inspected to the manufacturer's guidelines and by a certified clinical engineer.
5.2.3.2.4. Compliance with health and safety regulations and manufacturer's instructions and recommendations for the storage and charging of medical equipment.
5.2.3.2.5. Maintenance and servicing records for each major item of medical equipment.
5.2.3.2.6. The presence of information manuals and other data pertinent to each item of equipment.
5.2.3.3. All flight medical crew must receive instruction and competency checking for each item of equipment they are likely to use in flight.
5.2.3.4. A handbook or other such document (electronic application, tagged label, etc) containing relevant information on the service's medical devices should be made available to flight medical personnel to serve as a reminder on the use of complex equipment when on a missions.
5.2.3.5. The service must use comprehensive checklists for medical equipment carried on board aircraft and in ground vehicles.
5.2.3.6. Flight medical personnel shall ensure that all medical equipment is in working condition before the start of a mission.
<b>5.3. All medical consumables</b>
5.3.1. The service has stock-checking systems which tracks shelf-lives, servicing due dates, and levels of consumables immediately available for use.
<b>5.4. Medical capabilities</b>
5.4.1. Clinical Management During Missions
5.4.1.1. The service must demonstrate an appropriate method for selecting the number of flight medical crew on each mission, and their skill mix or specialty status.
5.4.1.2. The service must demonstrate that proper and adequate briefing and debriefing of flight medical teams and individuals is provided by the service.
5.4.1.3. Flight medical personnel are involved in the clinical decision making in terms of care provided during the mission.
5.4.1.4. The service must provide evidence of guidelines and other supporting documents aimed at ensuring the provision of optimum care (i.e. appropriate equipment, medical personnel and level of care) required for patients who are in need of aeromedical transport. These include:

5.4.1.4.1.	Policies on the management of specific clinical dilemmas.
5.4.1.4.2.	Policies on escalation of case management which require specialist or senior medical input.
5.4.1.4.3.	Algorithm driven clinical and logistic flow charts.
5.4.1.4.4.	Decision trees with clear end points on such issues as equipment, staffing, and logistics.
5.4.1.4.5.	Risk analysis and risk management strategies.
5.4.1.5.	Evidence of the following policies, protocols or procedures shall be provided:
5.4.1.5.1.	Pre-flight preparation of the mission requirements.
5.4.1.5.2.	Pre-flight assessment and preparation of the patient.
5.4.1.5.3.	In-flight medical procedures and capabilities.
5.4.1.5.4.	Clinical hand-over procedures.
5.4.1.5.5.	Medicolegal issues in patient transport.
5.4.1.5.6.	Procedures for tarmac transfers.
5.4.1.5.7.	Procedures for palliative/end of life transfers.
5.4.1.5.8.	Patient care during long haul missions.
5.4.1.5.9.	Patients with psychiatric disturbance.
5.4.1.5.10.	Patients with latex and other allergies.
5.4.1.5.11.	Venous thromboembolism risk assessment.
5.4.1.5.12.	Pressure area risk assessment.
5.4.1.5.13.	Safe management of complex patients.
5.4.2.	Patient Transport Documentation
5.4.2.1.	Evidence must be provided that preparation for transport is based on a patient medical report, clinical and logistic risk analysis, assessment of medical equipment and supplies needed, as well as the logistics and geography of the mission.
5.4.2.2.	Evidence shall also be provided that preparation for transport is based on a clinical and logistic risk analysis.
5.4.2.3.	A patient care transfer record is completed during every mission. Minimal requirements for items to be documented are:
5.4.2.3.1.	Purpose of the transport.
5.4.2.3.2.	Clinical assessment of patient prior to departure from point of origin.
5.4.2.3.3.	Patient condition at predetermined time intervals during the transfer.
5.4.2.3.4.	Treatment, medications and patient's response to treatment and medications.
5.4.2.3.5.	Transport modalities for all stages of the transfer.
5.4.2.3.6.	Transfer timings.

5.4.2.3.7. Names and professions of flight medical personnel.
5.4.2.3.8. Details of the referring and receiving medical teams and confirmation of receipt of clinical handovers.
5.4.2.4. Completed transport documentation is summarised and the data used to maintain a database of missions which forms part of regular auditing procedure and quality management.
5.4.2.5. Where there is no national limit for the time period that patient documents must be kept, the service shall provide evidence that historic records are kept in a secure store (or electronic database) for at least 7 years.
5.4.3. Infection Control
5.4.3.1. Policies and procedures shall address issues involving communicable diseases, infectious processes and health precautions for patients as well as for patient transport personnel.
5.4.3.2. The service must have a philosophy whereby all flight medical crew practice preventive measures reducing the likelihood of transmission of pathogens.
5.4.3.3. The infection control policy covers the following areas:
5.4.3.3.1. Use of gloves, goggles and masks for protection.
5.4.3.3.2. Hand cleaning and disinfection procedures and facilities.
5.4.3.3.3. Disposal of sharps.
5.4.3.3.4. Disposal of waste and soiled products.
5.4.3.3.5. Cleaning and/or sterilisation of potentially contaminated instruments and equipment.
5.4.3.3.6. Cleaning and disinfecting of the airline cabin area, equipment, and personnel's soiled uniforms (or evidence of liaison with airlines to ensure that communication of risks and advise on infection control methods has been given- see 5.4.3.6 below).
5.4.3.3.7. Mechanism for identifying those at risk for exposure to rubella, measles and other childhood diseases.
5.4.3.3.8. Additional (external) resources pertinent to infection control must be identified in the policy.
5.4.3.4. A generic dress code addresses issues which are also relevant to infection control, specifically: sleeve length, hair length, style and cleanliness, laundry of uniform items, and the wearing of jewellery, watches, and other personal items that increase the risk of contamination or the spread of pathogens.
5.4.3.5. These policies and procedures must be readily available to all personnel working for the service.
5.4.3.6. A pathway exists for communication between flight medical personnel, airline cabin crew, airline engineers, ground ambulance providers and hospitals when exposure is suspected. This is to include necessary follow-up.
5.4.3.7. Management maintains confidential records related to blood borne pathogens including exposure incidents, post-exposure follow-up, hepatitis B vaccination status and training for all employees with occupational exposure.
5.4.4. Medical Emergencies in Flight

5.4.4.1.	The service provides guidance documents, such as policies, procedures and/or protocols that prepare flight medical crew for the possibility of medical emergencies in flight and recommends how these emergencies should be managed. These include:
5.4.4.1.1.	Recognition and immediate management of the acutely deteriorating patient.
5.4.4.1.2.	Management of cardiorespiratory arrest and peri-arrest in flight.
5.4.4.1.3.	Management of paroxysmal cardiac failure.
5.4.4.1.4.	Management of cardiac dysrhythmias.
5.4.4.1.5.	Management of shock.
5.4.4.1.6.	Management of anaphylaxis.
5.4.4.1.7.	Management of emergencies in spinal patients.
5.4.4.1.8.	Management of respiratory emergencies.
5.4.4.1.9.	Management of neurologic and neurosurgical emergencies.
5.4.4.1.10.	Management of endocrine emergencies.
5.4.4.1.11.	Management of the combative patient.
5.4.4.2.	Depending on the mission statement and scope of the service, these guidance documents might also include:
5.4.4.2.1.	Difficult airway management.
5.4.4.2.2.	Rapid sequence intubation.
5.4.4.2.3.	Failure to oxygenate or ventilate.
5.4.4.3.	There shall be evidence of training to support these policies, for all flight medical personnel, within the bounds of each crew member's professional limitations.
<b>5.5. Equipment checklists</b>	(Each service is different. The checklists are a guide, and will vary according to the service's scope of service)
5.5.1.	Medical Material and Equipment
5.5.1.1.	Patient Carriage and Movement
5.5.1.1.1.	Vacuum mattress.
5.5.1.1.2.	Carrying sheet or transfer mattress.
5.5.1.1.3.	Memory foam mattress.
5.5.1.1.4.	Scoop stretcher.
5.5.1.1.5.	Isolated extremity immobilisation devices (Sager, Hare, Donway, etc).
5.5.1.1.6.	Upper spinal immobilisation collars.
5.5.1.2.	Basic airway and oxygenation
5.5.1.2.1.	Portable oxygen cylinder (minimum 400 L capacity) with regulator.

5.5.1.2.2.	Portable Oxygen Concentrator device (minimum 3L/min continuous flow rate)
5.5.1.2.3.	Flow meter (standard).
5.5.1.2.4.	Flow meter (low flow).
5.5.1.2.5.	Spare Bodok seals for independent cylinders.
5.5.1.2.6.	Spare oxygen cylinder key/spanner for independent cylinders.
5.5.1.2.7.	Oxygen masks (with and without reservoir/rebreathing; fixed fraction; anaesthetic).
5.5.1.2.8.	Nasal cannulae.
5.5.1.2.9.	Nebulisation device.
5.5.1.2.10.	Oropharyngeal airways.
5.5.1.2.11.	Nasopharyngeal airways.
5.5.1.2.12.	A suction device and suction catheters.
5.5.1.3.	Advanced airway and ventilation ( <b>NB</b> It is understood that few CAME-only services offer critical care transport but, when offered, the following items are required):
5.5.1.3.1.	Bag/valve/mask with oxygen reservoir and tube to connect to oxygen source.
5.5.1.3.2.	Laryngoscope(s) with suitable blades.
5.5.1.3.3.	Endotracheal tubes (range of sizes) with connectors.
5.5.1.3.4.	ET Tube fixing materials.
5.5.1.3.5.	Tracheostomy kit (range of tracheostomy tubes; insertion stylets; inflation tube clamp; inflation syringe).
5.5.1.3.6.	Magill forceps.
5.5.1.3.7.	Alternative devices for difficult airway management kit (examples include but are not limited to: Combitube; LMA; FastTrach; Trachlight; straight blades, McCoy laryngoscope; bougie introducers).
5.5.1.3.8.	Air portable transport ventilator:
5.5.1.3.8.1.	Controlled and assisted ventilation.
5.5.1.3.8.2.	PEEP-valve, adjustable.
5.5.1.3.8.3.	CPAP system (intubated & non intubated patients).
5.5.1.3.8.4.	BIPAP/Bi-level system.
5.5.1.3.8.5.	Pressure and volume control.
5.5.1.3.8.6.	Triggered/non-triggered.
5.5.1.3.8.7.	Oxygen monitoring system.
5.5.1.3.8.8.	Low pressure alarm.

5.5.1.3.8.9.	Oxygen supply tubing with various connectors.
5.5.1.3.9.	Chest drainage kit (thoracostomy tube; drainage bag; surgical instruments).
5.5.1.3.10.	Heimlich valve or Asherman seal.
5.5.1.4.	Circulation
5.5.1.4.1.	Appropriate equipment for placing and maintaining intra-venous access.
5.5.1.4.2.	Appropriate equipment for placing and maintaining intra-osseous access.
5.5.1.4.3.	Appropriate equipment for placing and maintaining intra-arterial access (obligatory for advanced critical care transport).
5.5.1.4.4.	Syringe driver(s).
5.5.1.4.5.	Infusion pump(s).
5.5.1.4.6.	IV pole(s) got mounting fluids.
5.5.1.4.7.	IV pressure bag(s).
5.5.1.5.	Patient Monitoring
5.5.1.5.1.	Cardiac monitor.
5.5.1.5.2.	12-lead ECG (obligatory for critical care transport).
5.5.1.5.3.	Defibrillator with rhythm display, recording, and documentation of patient data.
5.5.1.5.4.	External transcutaneous pacing (obligatory for advanced critical care transport).
5.5.1.5.5.	Automatic non-invasive BP monitoring system.
5.5.1.5.6.	Invasive BP monitoring system (obligatory for advanced critical care transport).
5.5.1.5.7.	Pulse oximeter.
5.5.1.5.8.	Electronic temperature monitoring.
5.5.1.5.9.	End tidal capnometer (obligatory for advanced critical care transport).
5.5.1.6.	Diagnostic Equipment
5.5.1.6.1.	Stethoscope.
5.5.1.6.2.	Manual blood pressure device (sphygmomanometer or electronic).
5.5.1.6.3.	Thermometer (min. range 15C – 42C).
5.5.1.6.4.	Diagnostic light.
5.5.1.6.5.	Blood gas analyser (obligatory for critical care transport).
5.5.1.6.6.	Blood labs analyser(s) for haemoglobin and electrolytes (obligatory for critical care transport).
5.5.1.6.7.	Blood glucometer.
5.5.1.7.	Nursing

5.5.1.7.1.	Vomit bag.
5.5.1.7.2.	Kidney bowl.
5.5.1.7.3.	Bed pan.
5.5.1.7.4.	Bed pan inserts.
5.5.1.7.5.	Non-glass urine bottle or receptacle.
5.5.1.7.6.	Absorbent gel.
5.5.1.7.7.	Biological fluids spill kit.
5.5.1.7.8.	Sharps container.
5.5.1.7.9.	Bedding equipment (sheets; blankets; pillows; pillow cases).
5.5.1.7.10.	Waste bags (standard and clinical).
5.5.1.7.11.	Wound treatment materials.
5.5.1.7.12.	Treatment materials for wounds caused by burns and corrosives.
5.5.1.7.13.	Adhesive fixing materials.
5.5.1.7.14.	Nasogastric tube with accessories.
5.5.1.7.15.	Sterile surgical gloves.
5.5.1.8.	Personal Protection
5.5.1.8.1.	Skin cleaning and disinfection material.
5.5.1.8.2.	Non-sterile gloves.
5.5.1.8.3.	Aprons.
5.5.1.8.4.	Goggles.
5.5.1.8.5.	Face masks/guards.
5.5.1.9.	Miscellaneous
5.5.1.9.1.	Small surgical kit (e.g. scalpels, suture holder, forceps, scissors, clamps etc, as per scope of the service).
5.5.1.9.2.	Emergency delivery set (as per scope of the service).
5.5.1.9.3.	Physical restraint systems (as per scope of the service).
5.5.1.9.4.	International electrical adaptors for medical equipment.
5.5.1.9.5.	Cool box for medications and temperature sensitive consumables.
5.5.1.9.6.	Temperature monitoring recorder (non-clinical) for cool box.
5.5.1.9.7.	Electrically powered medical devices shall have a self-contained power supply so that the devices do not rely on the power supply from the aircraft.

## Section 6. Interface with Transport Providers

### 6.1. General

6.1.

6.1.1. The service shall maintain a database of the capabilities and quality of each provider and partner which it utilises for the transport of patients.

6.1.2. Providers and partners will be audited from time to time in order to maintain quality assurance.

6.1.3. The service shall demonstrate evidence that care on each mission is optimised by a clear understanding of the capability, quality and safety of the transport provider.

6.1.4. The service shall demonstrate decision making processes which ensure that the transport mode (such as: commercial airliner, air ambulance or air taxi) is the most appropriate vehicle/method for each patient.

6.1.5. The service shall demonstrate decision making processes which ensure that the carriage mode (such as: stretcher, flat-bed, business seat, economy seat) is the most appropriate mode for each patient.

6.1.6. The service shall give evidence that decisions on transport and carriage mode are based only on clinical needs, and are not adversely influenced by budgetary constraints.

6.1.7. The service shall provide evidence that enquiry is made about all items of equipment that are supplied by transport providers - to ensure compatibility, capability, operability and serviceability (such as: stretchers, on-board oxygen, and bedding).

6.1.8. The service shall provide evidence of communication with regards to risks to the transport provider, for instance in cases of transmissible disease or when patients may be disruptive.

6.1.9. The service shall provide evidence that enquiry is made about methods for lifting and loading on to the aircraft for each mission.

6.1.9.1. The safe loading and unloading of patients must be possible under all operational conditions.

6.1.9.2. Approved manual handling techniques must be practiced by all staff.

6.1.9.3. When other ground handlers, not employed by the service, are utilised to assist with lifting, the flight medical escort(s) shall instruct and lead the helpers to ensure proper teamwork and correct lifting techniques.

6.1.9.4. The loading procedure must ensure that the patient's position remains horizontal.

6.1.9.5. The service must have a policy on the management of bariatric patients, including on the correct processes for loading and restraint.



6.1.9.6. The policy must also contain details of weight and dimensional limitations beyond which a bariatric patient will be refused carriage.

6.1.9.7. The cabin door must be large enough to ensure the patient can be moved into the cabin in a horizontal position without compromise to any continuous monitoring or treatment which cannot be temporarily disconnected.

6.1.9.8. The flight medical escort(s) must retain access to the patient during all stages of loading and unloading.

## **6.2. Airlines**

6.2.1. The service shall provide evidence of the use of MEDIF communications with airline authorities.

6.2.2. MEDIF (and similar medical reporting forms) shall be complete and honest in the information given about the patient and the patient's clinical and logistic needs.

6.2.3. Discussions with airline medical departments, patient support teams, booking office, and other interested parties shall be copied or transcribed in the mission files.

6.2.4. Where an airline refuses to carry a patient, the mission file shall record the reason(s) for the refusal.

## **6.3. Aircraft Charter**

6.3.1. The service acknowledges that it has a responsibility to maintain the quality of its service by ensuring the quality, capability, and safety of its transport providers, whenever and wherever reasonably practicable.

6.3.2. The service shall demonstrate evidence that when it utilises non-airliner aircraft for patient transport, it is consistent in its approach to quality and capability of the choice of transport provider.

6.3.2.1. The service shall preferentially choose a EURAMI accredited air ambulance company as its transport provider.

6.3.2.2. When not possible, the service shall preferentially choose a transport provider with other similar accreditation, or which the service, itself, has audited and approved, using guidelines similar to those published by EURAMI.

6.3.3. The service shall not abrogate its responsibilities if using the services of a broker to identify a transport provider.