EURAMI Commercial Airline Medical Escort (CAME) Standards V. 2.0.

November 7th, 2023

EURAMI CAME 2.0

Section 1. Business & Ethos
The aeromedical service is fully dedicated to a culture of customer and patient centricity, reflected in the following sections.
1.1. Business ethos
1.1.1. The aeromedical service has a written mission statement, clearly and concisely defining its purpose, corporate strategy and core values
1.1.2. The aeromedical service has a written code of ethical conduct that demonstrates ethical practices in business and marketing. The code is to include:
1.1.2.1. A letter / statement from the CEO outlining company values, company stakeholders expected behaviours, unacceptable and prohibited behaviours and sanctions for violations of code
1.1.3. The aeromedical service is properly directed and staffed according to the mission statement, anticipated individual needs, and scope of services offered
1.1.4. The aeromedical service operates an accredited management system relevant to commercial repatriations
1.2. Legal compliance
1.2.1. The aeromedical service demonstrates compliance with the legal requirements and regulations of the government.
1.2.2. The aeromedical 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 behalf of the service shall maintain due confidentiality in respect of all third parties
1.3. Processes
1.3.1. The aeromedical service has a written due diligence process and conducts desktop audits of their regular external providers of patient transport (e.g ground and air ambulances, handling agents, travel agents)
1.3.2. The aeromedical service has an Emergency Response Plan (ERP) in the case of an organisational or mission emergency
1.3.3. The aeromedical service has a Business Continuity Plan (BCP)
1.3.4. The aeromedical service has established technical and organisational measures (TOMs) based upon their processes to ensure data security within the confines of their legislation
1.3.5. The aeromedical service has clear rules for subcontracting to / chartering from other aeromedical providers to ensure transparency for its customers. This does not include Wing 2 Wing missions
1.3.6. The air ambulance service has established an informed consent process, including:
1.3.6.1. Transparent pricing which can be understood by a layperson
1.3.6.2. Indicates if a 3rd party has to pay all or a portion of the costs
1.3.6.3. If the patient / family is responsible for any portion of the costs of transport
1.3.6.4. Confirmation that cover is obtained where costs are to be paid by an insurance provider
1.3.6.5. If the service is rendered by a third party
1.4. Financial requirements

1.4.1. The aeromedical service must declare its source(s) of funding and provide evidence of financial security. A statement from an external accountant/ auditor is sufficient
1.4.2. The service must provide a description of the way the service is funded, supported by evidence from audited accounts / financial statement or similar
1.4.3. A sheet from an external accountant or auditing company for the last three years of operation is needed prior to the audit
1.4.3.1. Note: If the Service has been in operation for less than three years, the EURAMI Board will take a joint decision on whether the provider can be accredited
1.4.4. Independent auditors must report on the business financials at the intervals required under corporation law in the service's base country. A statement from the accountant is sufficient
1.5. Insurance
1.5.1. The aeromedical service shall hold an appropriate level of insurance cover (according to the scale of the scope of its business) in the following areas:
1.5.1.1. Third party liability cover for each aircraft with limits set by the relevant aviation regulatory body
1.5.1.2. Malpractice indemnity cover for health care professionals with an appropriate level of insurance in their country a min. 3 million USD in the aggregate (or a sum deemed by the Auditor to be appropriate to the country in which the Service operates)
1.5.1.3. Mission-related health insurance, including injury and accident cover with death in service benefits
1.5.1.4. Loss or damage of essential assets - medical equipment
1.6. Human capital and resources
1.6.1. There is a clear indication that service personnel are the most important factor for success, in that their motivation, education and training contribute decisively to meet high-level quality standards
1.6.2. There shall be evidence that staff are valued and recognised for their contributions to the success of the service
1.6.3. Staff shall receive feedback and appraisals at regular intervals
1.6.4. Service shall demonstrate a consistent means of keeping staff up to date on HR issues, business policy and other management issues associated with their roles within the service
1.6.5. There are clear functional and professional reporting lines
1.6.6. There is a clear disciplinary process, designed to protect patients, employees and the business
1.6.7. Staff members should be able to freely discuss concerns about the service, management and other related issues without fear of censure or retaliation
1.7. Leadership and Decision Making
1.7.1. There shall be a well-defined scope and limits of decision making for all employees
1.7.2. An accurate and contemporaneous organisational chart defines how the aeromedical transport service fits into the wider business / organisation
1.7.3. The Aeromedical Service should have at least three discrete departments or organisational functions including:
1.7.3.1. Aeromedical Operations (Mission Coordinators, Safety Manager)
1.7.3.2. Medical (which will include Medical Operations, Clinical Services and Medical Support)
1.7.3.3. Commercial / Administrative (including Financial, Sales, Marketing and Business Development)
1.7.4. Evidence shall demonstrate that management encourages ongoing communication between aircrew, flight medical crew, operations/communications personnel, engineers and other personnel

1.7.5. Evidence shall demonstrate that information regarding medical, logistic, safety and management issues are effectively communicated to staff (e.g. regular meetings, emails, newsletters etc)
1.8. Marketing
1.8.1. The aeromedical 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 aeromedical service
1.8.1.2. Type and scope of patients carried by the aeromedical service (defined by age, level of care and any specialist needs)
1.8.1.3. If the provider uses any third party providers (e.g. ground ambulances, other aeromedical programs etc)
1.8.1.4. 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. Employees are given training on the ethical and responsible use of social media
1.8.4. The senior management shall set guidelines for press related issues and marketing activities
1.9. Environmental
1.9.1. The aeromedical service demonstrates an awareness and focus on improving long-term environmental impact and sustainability through:
1.9.1.1. Evidence of a review of its current environmental impact across all operations (not more than 12 months old)
1.9.1.2. Plans to minimise its CO2 emissions in the longer-term
1.9.1.3. Policies to ensure recycling within its operations
1.9.1.4. Evidence of focus on reducing environmental impact wihtin its facilities and ground operations
1.10 Brokering (Brokering refers to missions that are conducted by a third party but operated commercially by the Provider and its brand (the subject of this audit)
1.10.1.Where arrangements like this exist, they should be clear and transparent to all parties, including the end client and EURAMI
1.10.2 When a third party is selected, every effort should be made to select a EURAMI-accredited provider when geographically feasible. When not using a EURAMI-accredited provider, the selection of the third party should be justified in writing and provided to EURAMI as evidence during the audit
1.10.3. There should be written consent / approval from the client to use the third party prior to mission dispatch
1.10.4. Brokering of missions to third parties should be limited to no more than 10% of the Provider's annual activity. (excluding Wing to Wing Missions - see next section)
1.10.5. The Provider maintains overall responsibility for the safety and quality of missions conducted by third parties
1.10.6. Missions that use third parties should have clear lines of reporting and accountability
1.10.7. Clinical and aviation personnel experience and expertise on the mission should be equal to or above the level of the provider's own personnel
1.10.8. The quality of aviation and medical equipment / assets should be equivalent to or exceeding those in use by the Provider
1.10.9. Lines of communication (including in-mission clinical advice) between the Provider and third party should be clearly defined and unambiguous
1.10.10. Third party missions should have at least the same level of insurances (both medical and mission related) as missions operated by the Provider alone

1.11. Wing to Wing Missions (Refers to missions of greater than 1 leg, where an external third party provider flies one or more of the mission legs in addition to the primary provider)
1.11.1.Where arrangements like this exist, they should be clear and transparent to all parties, including the end client and EURAMI
1.11.2 When a third party wing to wing partner is selected, every effort should be made to select a EURAMI-accredited provider when geographically feasible. When not using a EURAMI-accredited provider, the selection of the third party should be justified in writing and provided to EURAMI as evidence during the audit
1.11.3. There should be written consent / approval from the client to use the third party prior to mission dispatch
1.11.4. The Provider maintains overall responsibility for the safety and quality of the entire mission
1.11.5. Wing to wing missions should have clear lines of reporting and accountability
1.11.6. Clinical and aviation personnel experience and expertise of the wing to wing partner should be equal to or above the level of the provider's own personnel
1.11.7. The quality of aviation and medical equipment / assets used by the wing to wing partner should be equivalent to or exceeding those in use by the Provider
1.11.8. Lines of communication (including in-mission clinical advice) between the Provider and wing to wing partner should be clearly defined and unambiguous
1.11.9. Wing to wing missions should have at least the same level of insurances (both medical and aviation) as missions operated by the Provider alone

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Section 2: Safety & Quality
2.1. Quality Control
2.1.1. The CAME service has a clearly defined governance system and shall demonstrate methods used to develop and maintain high standards
2.1.2. There shall be formal, periodic department and interdepartmental meetings for which minutes are kept
2.1.3. The CAME service has a quality manager who oversees all aspects of quality assessment and control across the complete range of services provided by the organisation
2.1.4. The CAME service has a quality management committee that meets on a regular basis
2.1.5. There is a clear trail of accountability for quality management in all areas of the Service
2.1.6. The CAME service has a written policy defining the Quality Management System and its processes
2.1.7. The quality policy is understood and followed at all levels and by all staff and each employee and/or subcontractor works towards measurable objectives
2.1.8. The CAME service has defined key performance indicators (KPIs) and quality targets (QTs)
2.1.9. 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
2.1.10. Mission KPIs and QTs are based on written logistics and operations guidelines, policies, or protocols written by the CAME Service according to its mission statement, scope of service, and capabilities
2.1.11. The CAME Service produces regular quality control reports (at least annually)
2.2. Quality Audit Processes
2.2.1. The CAME Service has 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 (at least every 2 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 and 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 quality management meetings include representation from each of the relevant departments within the service (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 CAME service makes decisions about quality based on recorded data
2.4.2. The CAME Service keeps a record of all missions flown and these must be appropriately categorised (see below)
2.4.2.1. Transport Logistics which can include:
2.4.2.1.1. Total number of transport missions
2.4.1.1.2. Total transport time per mission
2.4.2.1.3.Total mission time
2.4.2.2. Type of Flight Medical / Non-Medical Escort used, which may include:
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 team
2.4.2.2.12. Total flights with other specialist teams
2.4.2.2.11. Total flights with psychiatric team
2.4.2.2.12. Total flights with other specialist teams
2.4.2.2.13. Total flights with a non-medical / clinical escort
2.4.2.3. Classification of missions by clinical information
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 (standard vs advanced vs ICU care)
2.4.2.3.3. Total flights by age group of patient (adult, paediatric, neonate)
2.4.2.3.4. Total flights by reason for the patient transfer (parameters must be given)
2.4.2.4. Mission Adverse Events and Outcomes:
2.4.2.4.1. Medical adverse events during the mission
2.4.2.4.2. Clinical outcomes in case of adverse events
2.4.2.5.1. Patient and Client Feedback:
2.4.2.5.2. Total complaints reported and outcomes
2.4.2.5.3. Total operations/logistics incidents reported and outcomes
2.4.2.5.4. Patient and/or family satisfaction

2.4.2.5.5. Commissioning agent/person satisfaction
2.5. Safety Management
2.5.1. Safety management system:
2.5.1.1. The CAME service has a safety manager who oversees all aspects of aviation related safety issues across the complete range of services provided by the organisation
2.5.1.2. The CAME service has adopted a culture of safety that is recognised and followed by its staff
2.5.1.3. There is a clear trail of accountability for safety management in all areas of the service
2.5.1.4. The CAME service has a written policy defining the SMS and its processes
2.5.1.5. The SMS policy shall:
2.5.1.5.1. Show clear evidence of adherence to the "Just Culture", namely that individuals are not blamed or punished for 'honest errors', but are held accountable for wilful violations and gross negligence
2.5.1.5.2. Define how the service is set up to manage risk
2.5.1.5.3. Describe a safety reporting system
2.5.1.5.4. Allow identification of risk
2.5.1.5.5. Support the implementation of suitable controls
2.5.1.5.6. Provide a process to identify and correct non-conformities
2.5.1.5.7. Define a continual improvement process
2.5.1.6. The safety management system is understood and followed at all levels and by all staff and/or subcontractors
2.5.1.7. 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 consist 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. Written reports on the activities of, and decisions made by, the safety committee shall be submitted to senior management meetings
2.5.2.4. Recommendations for amendments to operational and safety issues must be reviewed by senior management
2.5.3. Safety Reporting
2.5.3.1. The CAME 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. All safety reports are discussed at safety committee meetings
2.5.3.4. The Safety Manager has authority to escalate safety reports to senior management at any time
2.5.3.5. As determined by the evaluation of the Safety Manager, each applicable safety report is followed by an action plan (e.g. a root cause analysis and corresponding action plan)
2.5.3.6. 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 CAME service operates a risk control process that:
2.6.2.1. Allows identification of hazards and risks during the planning of each mission
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
2.6.3. Staff members shall have a designated manager with whom they can discuss concerns about the service, its procedures, safety, or any other issue, without fear of detriment or retaliation

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Section 3: Operations
3.1. Organizational Structure
3.1.1. The logistics and support needed to successfully complete a commercial medical escort mission are managed by an Operations or Medical Department
3.1.2. Daily activities of operations are managed by an operations or medical department manager
3.1.3. Where a non-medical Operations Department is involved, suitability of CAME transfers have to be confirmed by the Medical Department
3.2 Medical Control and Compliance
3.2.1. The Medical Director's role and responsibilities need to be clearly defined and well-understood by all Operations personnel
3.2.2. The Medical Director (or named deputy) has active involvement in mission planning, mission conduct and mission debrief
3.3 Escalation Policy
3.3.1. There is an escalation policy for dealing with issues (including emergencies and delays) that may occur during a mission.
3.3.2. It should define appropriate methods of communication, the 'chain of command,' individual responsibilities and plans of action
3.4 Duties and role of Operations Personnel in regard to CAME
3.4.1. Coordinate communications and organization internally and externally in all aspects related to the safe and efficient undertaking of a commercial medical transport missions
3.4.2. Receive calls from clients and commissioners of commercial medical escort transports
3.4.3. Issue quotes and/or estimates for missions when requested by outside agencies
3.4.4. Receive and coordinate requests for aeromedical transports
3.4.5. Send and receive patient medical reports in accordance with local data protection laws
3.4.6. Assign the medical team according to the request, considering language, visa, vaccination and other such requirements
3.4.7 Set up logistic stages of each sector in the mission plan as outlined in below mission planning
3.4.8. Book flights for medical escort team, patient and relatives as requested
3.4.9. Booking of ground transport (i.e., ambulances, taxis etc)
3.4.10. Access medical crew visas and passport information in order to complete medical escort mission documentation and flight booking
3.4.11. Track mission progress (flight following)
3.4.12. Communicate with medical team on-mission
3.5 Medical or Operations Personnel - Company Orientation
3.5.1. There is an induction and training programme for the medical and/or operations personnel
3.5.2. The induction programme should include orientation in the following areas:

3.5.2.1. Company Briefing
3.5.2.2. Department and Reporting Structure
3.5.2.3. Communication tools and policies
3.5.2.4. Aspects of relevant company financial controls and policies
3.5.3. Proof of induction / orientation should be documented (e.g. via a checklist kept in the staff record)
3.6 Medical or Operations Personnel Training
3.6.1. Training of Medical/ Operations Personnel shall follow a training syllabus
3.6.2. The training syllabus should include :
3.6.2.1. Use of the service's case management IT system.
3.6.2.2. Financial aspects of quoting and estimating missions
3.6.2.3. Basic knowledge of Aviation Physiology
3.6.2.4 Knowledge of IATA Guidlines in regard to medical patient transport on commercial airline, including importance of patient clearance
3.6.2.5. Geographical limits and other considerations applicable to the aeromedical service
3.6.2.6. Border control regulations (immigration and customs)
3.6.2.7. 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.
3.6.2.8. Company safety regulations and emergency procedures
3.6.2.9. Safety Management System (SMS)
3.6.2.10. Mission logistics planning
3.6.2.11. Fatigue policy for medical escorts
3.6.2.12. Flight following (tracking) procedures
3.6.2.13. Major incident co-ordination
3.6.2.14. Arranging ground ambulance when required
3.6.2.15. The capabilities and resources of airports, ground ambulance suppliers, receiving hospitals and other facilities that are needed for a successful mission outcome
3.6.2.16. The SMS (Safety Management System), safety policies and procedures
3.6.2.17. The Service's QMS (Quality Management System) including relevant policies and procedures
3.6.2.18. The handling and sourcing of MEDIF's (Medical Information Forms) / flight clearances
3.6.2.19. Communication skills, including patient and client relationship management
3.6.3. An end-of-training evaluation completes the training and is documented for each member of Medical / Operations Personnel
3.7. Operational Data and Security
3.7.1 Data Compliance and Confidentiality
3.7.1.1. The aeromedical service demonstrates that the security of the data collected meets the high standards required for national data protection/confidentiality laws

3.7.1.2. The aeromedical service provides evidence that this data is used to improve the quality, safety, efficacy and efficiency of the service
3.7.1.3. The Aeromedical Service ensures that the findings from internal audits and research are:
3.7.1.3.1. Distributed widely across the Service in order to promote quality and service improvement
3.7.1.3.2. Where appropriate, shared externally for the benefit of the wider industry. E.g. through the EURAMI Forum or in peer-reviewed journals
3.7.1.4. Staff take steps to minimise noise and other distractions when an open-plan environment is used for operational communications
3.7.1.5. Real-time communication tools, such as email and mobile devices meet the requirements of patient- and general data protection laws
3.7.2. Alarm / Call Centre
3.7.2.1. The alarm/ call centre is available and accessible at all times during missions
3.7.2.2 There is at least one dedicated phone line for aeromedical transport co-ordination
3.7.2.3. There is at least one dedicated alternative phone line for aeromedical transport communications
3.7.2.4. There is at least one dedicated email address for aeromedical transport communications
3.7.2.5. Telephone and email responses are handled quickly enough to allow for immediate response to in-mission emergencies
3.7.3. Call Management
3.7.3.1. Incoming and outgoing phone calls are recorded
3.7.3.2. Parties are informed if their conversation are recorded as per national laws
3.7.3.3. Recordings are time stamped and may be played back directly by communication`s personnel
3.7.3.4. A communications log is kept in the event calls are not recorded
3.7.4. Online Portal / Database
3.7.4.1. There is an electronic case management software tool. This tool shall be used to gather medical and case related data centrally
3.7.5. Back-Up Power
3.7.5.1. In the case of loss of mains power to the IT and communication equipment there is a back-up emergency power source for communications equipment
3.7.5.2. In the event of a power outage, there is a policy and alternative means of communication
3.7.6. Daily Status Board
3.7.6.1. There are real or virtual status board(s) easily accessible to the medical operations teams. Information may include:
3.7.6.1.1. Booked medical escort flights
3.7.6.1.2. Medical escort flights in progress
3.7.6.1.3. Flight medical crew on duty and standby (availability)
3.7.6.2. The status board is regularly updated and is part of the handover process at shift changes
3.7.7. Internal and External Communications
3.7.7.1. There is an internal communication policy or a set of procedures
3.7.7.2. The policy has to highlight the exclusive use of the online communication platforms established for flight operations (i.e.WhatsApp, e-mail, social media) for business purposes only, no personal use

3.7.7.3. Any online platforms must conform to general data protection laws and be used appropriately in terms of good information governance (e.g. minimum required information and strict access control)
3.7.7.4. A policy should outline customer relations with regard to customer complaints, feedback, follow up and documentation
3.8. Other Operational Considerations
3.8.1. Audit
3.8.1.1. Through a defined process, expiration dates of medical escort documents like passports, visas, vaccinations & certificates, travel insurance, etc. are reviewed and communicated to all relevant parties
3.8.2. Crew Requirements
3.8.2.1. A defined process ensures that professional licences, medical certificates as required for the medical escort service are current

Section 4: Medical Standard + Advanced
Definition :Patients who are unlikely to medically deteriorate during flight but who do require nursing care. For example, simple oxygen therapy, an IV infusion or a urinary catheter. Patients who do not require nursing attention in flight but who might need assistance with mobility or bodily functions (i.e. arm cast: assistance with clothing or with meals). Patients able to move about of their own volition in an emergency or sitting patient including handicapped persons, who, in an emergency, would require assistance to escape.
4.1. Medical Department - Overview
4.1.1. The Service has a dedicated and integrated Medical Department. The organisation of the Department is well-defined and understood by all staff
4.1.2. It is clear and unambiguous how the Medical Department fits within the overall company structure, including key lines of accountability (shown on a company organisation chart)
4.1.3. The Medical Director has overall responsibility for patient care decisions as well as logistical considerations and works together with the Service's Executive Management on other organisational matters
4.1.4. Patient care and wellbeing should always be the primary concern of the organisation and should not be compromised for operational or commercial reasons, as reflected in the mission statement
4.1.5. All medical personnel shall understand the Medical Department chain of command, including reporting structure and who to contact for help
4.1.6. There should be an escalation structure to the Medical Director / delegated deputy available for medical crew guidance on missions at all times, this should be immediately available and outlined in a policy document
4.2. Scope of Medical Service
4.2.1. The Service has a well-defined scope of service that is known and understood by all staff
4.2.2. The Medical Director, with the support of an Assistant or any other Deputy with full delegated authority, is available 24/7/365 to deal with urgent clinical mission-related decisions
4.2.3. The Medical Director has overall responsibility for patient care decisions and works together with all stakeholders on other organisational matters
4.2.4. Missions are appropriately staffed and resourced according to the defined level of patient Standard Care (including Flight Medical Crew, medical equipment and consumables)
4.2.5. The Service has documented criteria regarding appropriate levels of Standard Care required by patients using the service. This shall include:
4.2.5.1. A description of the different levels of Standard Care and patient that can be transported for each level
4.2.5.2. Associated types and numbers of health care professionals that are required for each level of care
4.2.5.3. The minimum equipment set(s) that must be carried for each level of care
4.3. Medical Department - Key Post-Holders
4.3.1. The Medical Department employs appropriately qualified and experienced personnel in key organisational roles. Job titles may differ, but the roles should broadly cover the following:
4.3.1.1. Medical Director

4.3.1.2. Clinical Services Manager(s), which may be (as appropriate to the service provided):
4.3.1.2.1. Flight Nurse Manager
4.3.1.2.2. Flight Paramedic Manager
4.3.1.2.3. Medical Training Manager and Induction Course / CPD (Continuing Professional Development) Faculty - can be Medical Director and/or Clinical Services Manager
4.3.2. The Medical Department employs appropriately qualified and experienced personnel in the following flying roles (as appropriate to the service provided):
4.3.2.1. Flight Doctors
4.3.2.2. Flight Nurses
4.3.2.3. Flight Paramedics
4.3.2.4 Flight Non Medical Escort
4.3.3. Medical Director
4.3.3.1. The service employs a Medical Director who is available as necessary
4.3.3.2. The Medical Director, with the support of an Assistant or any other Deputy with full delegated authority, is available 24/7/365 to deal with urgent clinical mission-related decisions.
4.3.3.3. The Medical Director establishes and maintains a standard of high quality medical care provided by the Flight Medical Crew
4.3.3.4. The Service must provide a Resume / CV of the Medical Director with supporting documentation, demonstrating:
4.3.3.4.1. A full and unrestricted license to practice medicine from the Country and/or State in which the Service is based
4.3.3.4.2. Five or more years of clinical experience and qualifications in a relevant specialty (e.g. Intensive Care Medicine, Anaesthesia, Emergency Medicine)
4.3.3.4.3. Maintainance of clinical currency in an acute medical role
4.3.3.4.4. Full command of the official language(s) of the country in which the Service is based
4.3.3.4.5. A good working knowledge of the English language
4.3.3.4.6. Postgraduate training / qualifications in patient transfer from recognised courses and providers in transport medicine or aviation medicine
4.3.3.4.7. A thorough understanding of the concepts of safe and effective patient transfer, by ground and air
4.3.3.5. The Medical Director operates within the mission statement and scope of the Service and according to local and international standards
4.3.3.6. The Medical Director demonstrates sound clinical and logistical judgement when planning and undertaking mission
4.3.3.7. The Medical Director practices and promotes the provision of high standards of care for all patients using the Service
4.3.3.8. The Medical Director has other important areas of organisational responsibility which include:
4.3.3.8.1. Responsibility for recruitment, training and Continuous Professional Development for healthcare staff
4.3.3.8.2. Ensuring the continuing competency and currency of medical personnel
4.3.3.8.3. Development and maintenance of guidelines / SOP's relating to specific patient conditions and how they should be managed and digitally available to Medical Crew during patient transfer
4.3.3.8.4. Ensuring the Service has an effective framework of Clinical Governance, including audit, quality improvement, risk and medicines management
4.3.3.8.5. Chairs or attends regular Medical Department Governance / Quality meetings with the aim of improving patient care and service delivery.
4.3.4. Clinical Services Manager (if applicable)
4.3.4.1. The Service may employ, if applicable, in addition to the Medical Director, a Clinical Services Manager (CSM), who may be a Flight Nurse Manager

4.3.4.2. The CSM shall have knowledge and experience in both air and ground patient transport, depending upon the scope of the service and reports to the Medical Director (and other directors on non-clinical matters)
4.3.4.3.The CSM maintains clinical currency by undertaking regular external work and training in hospitals or clinics
4.3.4.4. The CSM should undertake regular flying duties (at least monthly) in order to maintain an effective service overview and flight currency
4.3.4.5. The role of the Clinical Services Manager shall include responsibility for, or oversight of the following (where not already a function of the Medical Director):
4.3.4.5.1. Responsibility for recruitment, training and Continuous Professional Development for healthcare staff
4.3.4.5.1.1. Day-to-day running of the Medical Department
4.3.4.5.1.2. Oversight of current and planned cases, working with the Medical Director
4.3.4.5.1.3. Clinical case management and appropriate escalation of complex cases to the Medical Director
4.3.4.5.1.4. Initial screening of completed case documentation, identification of issues for follow-up and reporting to the Medical Director
4.3.4.5.1.5. Medical Department human resources issues
4.3.4.5.1.6. Recruiting, interviewing, training records, currency and competency status for Flight Medical Crew
4.3.4.5.1.7. Maintenance of rotas, availability calendar, and key operability status board(s)
4.3.4.5.2. Stock management and procurement of:
4.3.4.5.2.1. Medicines
4.3.4.5.2.2. Medical equipment
4.3.4.5.2.3. Medical consumables
4.3.4.5.2.4. Portable oxygen concentrator (including batteries)
4.3.4.6. Restocking / management of medical equipment and pharmacy bags/stores following each mission
4.3.4.7. Management of contracts for external service providers in areas including:
4.3.4.8. Cleaning and disinfection of medical equipment
4.3.4.8.1. Waste and sharps disposal including witnessing and recording of disposal of controlled substances
4.3.4.8.2.Medical equipment servicing
4.3.4.8.3. Issuing of uniforms and appropriate personal protective equipment to Flight Medical Crew (uniforms and PPE to be separate)
4.3.4.9. Additional Clinical Services Manager duties may be shared with the Medical Director, and may include:
4.3.4.9.1. Reviewing and updating of Medical SOP's and Guidelines
4.3.4.9.2. Recruitment, training and Continuous Professional Development for non-physician medical personnel
4.3.4.9.3. Clinical and logistical decisions and advice regarding patient care
4.3.4.9.4. Daily allocation of Flight Medical Crew to missions, based on clinical need and risk analysis
4.3.4.9.5. Active involvement in Clinical Governance and Quality Improvement programs
4.3.4.9.6. Oversight of mission documentation, including medical reports, briefing notes and handover forms
4.3.4.9.7. Medical planning and prioritisation in conjunction with the Medical Director
4.3.5. Flight Doctors

4.3.5.1. All Flight Doctors employed by the Service shall comply with the following criteria:
4.3.5.1.1. Hold a current and unrestricted licence to practice medicine in a relevant specialty e.g. anaesthesia, intensive care medicine, emergency medicine, or family medecine from the country in which the Service is based
4.3.5.1.2. For Standard Care mission there should be at least 12 months experience in a relevant medical role e.g. Emergency Department, Family Medicine
4.3.5.1.3. Maintain clinical currency in a relevant medical role on at least a monthly basis
4.3.5.1.4. Has full command of the official language of the country in which the Service is based
4.3.5.1.5. Has a good working knowledge of the English language if the Service is operating internationally
4.3.5.1.6. Undertakes regular Continuous Professional Development relevant to the Flight Doctor role
4.3.5.2. Specific points when the Service uses temporary Flight Doctors
4.3.5.2.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.5.2.2. They should provide clinical care to a level that matches or exceeds the permanent medical staff
4.3.5.2.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine.
4.3.5.2.4 Corporate indemnity insurance should cover all permanently employed and 'bank' Flight Doctors roles
4.3.5.3. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director.
4.3.6. Flight Nurses
4.3.6.1. Each Flight Nurse meets national regulatory criteria for employment as a qualified and registered Nurse
4.3.6.2. Each Flight Nurse is trained by the Service and is familiar with Service's policies and procedures
4.3.6.3. For Standard care mission there should be at least 12 months experience in a relevant nursing role e.g. Emergency Department nursing
4.3.6.4. Maintain clinical currency in a relevant medical role on at least a monthly basis
4.3.6.5. Flight Nurses undertake regular Continuous Professional Development relevant to the Flight Nurse role
4.3.6.6. Specific points when the Service uses temporary Flight Nurses:
4.3.6.6.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.6.6.2. They should provide clinical nursing care to a level that matches or exceeds the permanent medical staff
4.3.6.6.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine
4.3.6.6.4. Corporate indemnity insurance should cover all permanently employed and 'bank' Flight Nurses roles
4.3.6.7. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director.
4.3.7. Flight Paramedics
4.3.7.1. Flight Paramedics must meet the essential national regulatory criteria for employment as a qualified and registered paramedic
4.3.7.2. Each Flight Paramedic is trained by the Service and is familiar with Service's policies and procedures
4.3.7.3. For Standard Care mission there should be at least 12 months experience as a frontline paramedic
4.3.7.4. Maintain clinical currency in a relevant paramedical role on at least a monthly basis
4.3.7.5. Flight Paramedics undertake regular CPD relevant to the Flight Paramedic role
4.3.7.6. Specific points when the Service uses temporary Flight Paramedics :

4.3.7.6.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.7.6.2. They should provide clinical paramedic care to a level that matches or exceeds the permanent medical staff
4.3.7.6.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine.
4.3.7.6.4. Corporate indemnity insurance should cover all permanently employed and 'bank' Flight Paramedics roles
4.3.7.7. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director.
4.3.8 Flight Non Medical Escort
4.3.8.1 Flight Non Medical Escort can be used upon decision and mutual agreement between Client and Service Medical Director
4.3.8.2 Service will have a dedicated procedure for the use of Flight Non Medical Escort specifying the required conditions when their activation as well as expectations in terms of patient support
4.3.9. Security Escort
4.3.9.1 Service will have a dedicated procedure for the use of Security Escort specifying the required conditions when their activation
4.3.9.1.1. Service will have a dedicated procedure describing which country or situation requires a security support
4.3.9.1.2. Service will have a dedicated procedure describing what type of security support is required for patient and medical team safety
4.3.10. Training Manager
4.3.10.1. A Training Manager (can be Medical Director and/or Clinical Service Manager) should be responsible for the content and delivery of the Service's training
4.4 Medical Department - Documentation and Patient Records
4.4.1.Evidence must be provided that preparation for transport is based on a patient medical report, assessment of medical equipment and supplies needed, as well as the logistics and geography of the mission under the full authority of Medical Director
4.4.2 Evidence shall also be provided that preparation for transport is based on a clinical and logistic risk analysis prior mission departure
4.4.2.1. Fit to Fly documentation or Risk Assessment documentation
4.4.2.2. Consent form signed by patient or Next of Kin
4.4.3. Patient care records, meeting minutes and policies / procedures are stored according to the Service´s Information Governance Policy and due respect is given to patient-sensitive and confidential information
4.4.4. Patient care records will be securely stored for the minimum period of time, as defined by local regulations
4.4.5. A copy of the patient care record is handed-over to the receiving facility or home address for appropriate continuity of care. Receiving Doctor/Nurse or Next of Kin must sign patient care record to confirm handover (date/time/signature)
4.4.6. If the Service uses an electronic patient record system, a paper-copy (or email) of the patient transfer record is given to the receiving facility at handover. Handover is confirmed by an electronic or physical signature from the receiving team
4.4.7. A Mission Case File is constructed for every mission (may be paper or electronic) and should include:
4.4.7.1. Requesting organisation, with corresponding date and time of the request
4.4.7.2. Patient demographics including Patient's first name, last name, date of birth, height, weight, and recumbent measurements to ensure stretcher and loading device suitability
4.4.7.3. The clinical and social status of the patient and any traveling companions
4.4.7.4. The patient's geographical location with details of the sending and receiving healthcare facilities

4.4.7.5. The planned modes of transportation including ground and commercial flights and the details of any third party providers
4.4.7.6. Communications log between provider and transferring facility to obtain a history of events and up to date clinical report prior to clinical team departure
4.4.8. The mission case file should be easily accessible to the Flight Medical Crew prior to and during the mission
4.4.9. A Patient Transfer Record is completed during every mission (paper or electronic) and should include:
4.4.9.1. Flight Medical Crew Identifiers and professions / seniority
4.4.9.2. Purpose of the transport
4.4.9.3. Important event timings e.g. take-off, and landing times, arrival times and timing of clinical events
4.4.9.4. Clinical assessment of the patient prior to departure from point of origin
4.4.9.5. Patient condition at predetermined time intervals during the transfer (including documentation of vital signs) - the frequency of observations is appropriate for the condition of the patient
4.4.9.6. Any treatments given or medical interventions made and the patient's response to the treatment
4.4.9.7. Transport modalities for all stages of the transfer
4.4.9.8. Details of the sending and receiving medical teams and confirmation of receipt of clinical handover
4.4.10. The completed Patient Transfer Record is summarised, the data from which is used to maintain a database of missions used for Clinical Governance
4.5. Medical Department - Clinical Policies, Procedures and Guidelines
4.5.1. There are provider-specific medical policies, guidelines and procedures supporting the delivery of high quality care and immediately available to all staff
4.5.2. The service must provide evidence of policy defining limitations in accepting Standard Care transport in commercial flight based on a risk-benefit analysis for the patient, crew, passengers
4.5.3. Policies are dated and signed by Medical Director
4.5.4. Policies are reviewed and updated (where needed) annually by Medical Director
4.5.5. There are policies on the management of specific clinical conditions that are commonly encountered by the Service
4.5.6. There is a policy on when / how to escalate a case during the quotation / planning phase for Medical Director input
4.5.7. Specific policies (or policy sections within a manual) should be in place for:
4.5.7.1. Medical risk identification, management and mitigation
4.5.7.2. Pre-mission preparation and planning including evidence that 1-Staff are completely cognisant of with the mission statement and scope of care of the service 2-Flight medical personnel are involved in the clinical decision making in terms of care provided during the mission
4.5.7.3. Initial patient assessment and preparation for flight / transfer
4.5.7.4. In-flight medical interventions / capabilities
4.5.7.5. Patient handover with duly documents signed
4.5.7.6. Medico-legal aspects of international transfers (e.g. movement narcotics / medicines management and physician licence to practice)
4.5.7.7. Management of traveling companions
4.5.7.8. Guidelines for palliative / end of life transfers (if undertaken)
4.5.7.9. Continuity of patient care on long haul missions and during aircraft delays / technical issues

4.5.7.10. Transportation of patients with psychiatric or mental health conditions (see below specific section 4.16.4)
4.5.7.11. Venous thromboembolism risk assessment and prophylaxis
4.5.7.12 Pressure area assessment, prophylaxis and treatment
4.5.7.13. Guidelines for patient transport documentation / electronic patient record completion
4.5.7.14. A generic Infection Control policy, which should include
4.5.7.14.1. Procedures for patients with infectious diseases, such as barrier nursing and post-mission disinfection
4.5.7.14.2. The use of PPE, such as masks and gloves along with effective hand hygiene
4.5.7.14.3. Disposal of sharps and clinical waste
4.5.7.14.4. Single use consumables where possible and procedures for effective disinfection & sterilisation for multi-use items
4.5.7.14.5. Cleaning and disinfecting of the equipment as well as Crew uniforms
4.5.7.14.6. A dress code for Flight Medical Crew that is appropriate for infection control
4.5.8. If the Service carries 'bariatric' patients (patients with larger body sizes) must be in place
4.5.8.1. Weight restrictions for seated/stretchers and related systems (such as loading equipment) should be clearly defined
4.5.8.2. Dimensions restrictions for the commercial fight cabin door, stretcher and cabin environment should be clearly defined
4.5.8.3. Specific manual handling procedures (including loading / unloading) should be defined (and trained / practised) when carrying bariatric patients
4.5.8.4. Any specialised equipment for the carriage of bariatric patients should be detailed, maintained to a good quality and all mission flight crew should be proficient in its use : stock or has readily available
4.5.8.5. Ground transportation should be considered and specific ground ambulances with enhanced capability for bariatric transfers should be used when appropriate
4.5.9. In the event of unexpected clinical complications during transfer, there should be:
4.5.9.1. A manual of medical emergencies that might be encountered during flight that is readily available to Flight Medical Crew during a live mission. This manual should include clearly defined standing order if and when physician lead procedures or interventions (iv access, medications, intubation, defibrillation etc.) are delegated to non-physician staff.
4.5.9.2. The manual should include common medical emergencies of the cardiorespiratory systems and how they are managed
4.5.9.3. The manual should include a flowchart that covers:
4.5.9.3.1. Immediate Management
4.5.9.3.2. Method of communication with Base / escalation for support and advice
4.5.9.3.3. When to divert or abandon the transfer, if no longer fit to fly (even when patient becomes unstable while on ground awaiting connecting flight)
4.5.9.4. Induction and Continuous Professional Development training for Flight Medical Crew Training should support the above policies
4.5.9.5. The Service must demonstrate that proper and adequate debriefing of flight medical teams and individuals is provided by the Service with appropriate preventive/corrective documented actions if necessary
4.6. Medical Department - Human Resources
4.6.1. All Flight Medical Crew must have an unrestricted licence to practice medicine, be registered, certified or permitted to practice according to local law and regulations
4.6.2. During the recruitment process, relevant background checks and 'due diligence' should be performed for all Flight Medical Crew

4.6.3. During the recruitment process, all Flight Medical Crew must meet a minimum 'Person Specification' or a minimum set of educational requirements according to the scope of service and their role within it
4.6.4. All Flight Medical Crew should act in an ethical and moral way, consistent with guidelines set out by the local / national healthcare licensing authority
4.6.5. There should be a company specific code of ethics and conduct for Flight Medical Crew
4.6.6. Flight Medical Crew skill retention is demonstrated via a mission log book and training portfolio kept up-to-date by both the individual and by the Service
4.6.7. All Flight Medical Crew should participate in a minimum number of regular missions in order to retain skills and knowledge. This will depend on the Service's volume of work, but should be defined in a Medical HR Policy
4.6.8. Medical Department - Appraisals and Performance Review:
4.6.8.1. All Medical Department staff have a regular (at least annual) formal appraisal from a manager, which should include a performance review and plan for the next period.
4.6.8.2. All routine appraisals should be formally documented and stored as part of the HR record
4.6.8.3. Extraordinary appraisals may be performed in exceptional circumstances, such as following critical incidents or for 'performance management' when performance falls below the standard expected
4.6.8.4. Any Extraordinary Appraisals or performance management reviews should be documented and kept as part of the HR record
4.7. Medical Department - Occupational Health
4.7.1. The Service has an Occupational Health Policy(s) that address the following issues:
4.7.1.1. Pre-employment due diligence checks should include occupational health screening and immunisation history
4.7.1.2. The Service keeps records on blood borne pathogen exposure incidents, post-exposure follow-up protocols and staff support
4.7.1.3. Employee 'equality and diversity' should always be considered during recruitment of new staff. Staff with additional needs should be treated equitably, within the scope and practicalities of the service
4.7.1.4. During the 'onboarding' process, consideration should be given to any chronic health condition and how the service might accommodate such conditions whilst maintaining a safe and effective environment for staff and patients
4.7.1.5. Each member of Flight Medical Crew should declare themselves physically and mentally fit to fly and to conduct the given mission prior to each mission dispatch
4.7.1.6. Staff should report any health-related issues that negates one Flight Medical Crew from flying or may affect their performance during a mission, such as the use of chronic medication (e.g. sedatives) or a recent history of diving
4.7.1.7. The Service shall have a uniform policy which includes personal protective equipment (PPE) and how this should be used
4.7.1.8. Crew duty-time limitations and breaks for Flight Medical Crew that recognises the issue of crew fatigue and implements appropriate safeguards
4.7.1.9. If appropriate, the use of hearing protection on the ground and in the air in environments experiencing excessive noise, as defined by local laws
4.7.1.10. An absence policy that should include specific guidelines around working during pregnancy or when suffering from acute illnesses such as gastrointestinal upset
4.7.1.11. There should be a policy on (and training for) Manual handling (lifting and loading)
4.7.1.12. There should be a specific drugs and alcohol misuse policy
4.8. Flight Medical Crew Training

4.8.1. There should be a structured Induction Course as part of staff 'on-boarding' and regular Continuous Professional Development at least annually for all Flight Medical Crew
4.8.2. Training should be available to all Flight Medical Crew and a full training record should be kept as part of the individual's HR record
4.8.3. Training is mapped against aeromedical competencies defined by the Clinical Service Manager or Medical Director according to training course content
4.8.4. Completion of training is documented for each member of Flight Medical Crew and is a pre-requisite before undertaking any unsupervised live missions
4.8.5. Attendance and performance at Induction Training and CPD (Continuous Professional Development) is documented in a training record and forms part of the annual appraisal
4.8.6. Training should be offered with a combination of face to face and online / distance learning, appropriate to the needs of the Service and local healthcare regulation
4.8.7. Induction Training and CPD should cover a range of topics including , but not limited to the following:
4.8.7.1.1. General company introduction including company history
CAME 2.0. ADVANCED CARE TRANSPORT
Definition : All Patients needing more medical/technical support than Standard Care.
4.1. Medical Department - Overview
4.1.1. The Service has a dedicated and integrated Medical Department. The organisation of the Department is well-defined and understood by all staff
4.1.2. It is clear and unambiguous how the Medical Department fits within the overall company structure, including key lines of accountability (shown on a company organisation chart)
4.1.3. The Medical Director has overall responsibilty for patient care decisions as well as logistical considerations and works together with the Service's Executive Management on other organisational matters
4.1.4. Patient care and wellbeing should always be the primary concern of the organisation and should not be compromised for operational or commercial reasons, as reflected in the mission statement
4.1.5. All medical personnel shall understand the Medical Department chain of command, including reporting structure and who to contact for help
4.1.6. There should be an escalation structure to the Medical Director available for medical crew advice on missions at all times, this should be immediately available and outlined in a policy document
4.2. Scope of Medical Service
4.2.1. The Service has a well-defined scope of the service that is known and understood by all staff
4.2.2. The Medical Director, with the support of an Assistant or any other Deputy, with full delegated authority, is available 24/7/365 to deal with urgent clinical mission-related decisions
4.2.3. The Medical Director has overall responsibility for patient care decisions and works together with all stakeholders on other organisational matters
4.2.4. Missions are appropriately staffed and resourced according to the defined level of patient care (including Flight Medical Crew, medical equipment and consumables)
4.2.5. The Service has documented criteria regarding appropriate levels of care required by patients using the service. This shall include:
4.2.5.1. A description of Advanced Care / patient groups that can be transported

4.2.5.2. Associated types and numbers of health care professionals that are required for Advanced Care
4.2.5.3. The minimum equipment set(s) that must be carried for Advanced Care
4.3. Medical Department - Key Post-Holders
4.3.1. The Medical Department employs appropriately qualified and experienced personnel in key organisational roles. Job titles may differ, but the roles should broadly cover the following:
4.3.1.1. Medical Director
4.3.1.2. Clinical Services Manager(s), which may be (as appropriate to the service provided)
4.3.1.2.1. Flight Nurse Manager
4.3.1.2.2. Flight Paramedic Manager
4.3.1.2.3. Medical Training Manager and Induction Course / CPD Faculty
4.3.2. The Medical Department employs appropriately qualified and experienced personnel in the following flying roles (as appropriate to the service provided):
4.3.2.1. Flight Doctors
4.3.2.2. Flight Nurses
4.3.2.3. Flight Paramedics
4.3.2.4. Flight Respiratory Therapists
4.3.2.5. Other non-physician healthcare professionals / Associated Healthcare Professionals (AHP's - e.g. midwives and physiotherapists)
4.3.2.6. Expert medical personnel key to any specialist aspects of CAME Critical Care (e.g. neonatal care, psychiatric care, ECMO etc)
4.3.3. Medical Director
4.3.3.1. The service employs a Medical Director who is available as necessary
4.3.3.2. The Medical Director, with the support of an Assistant or any other Deputy with full delegated authority, is available 24/7/365 to deal with urgent clinical mission-related decisions.
4.3.3.3. The Medical Director establishes and maintains a standard of high quality medical care provided by the Flight Medical Crew
4.3.3.4. The Service must provide a Resume / CV of the Medical Director with supporting documentation, demonstrating:
4.3.3.4.1. A full and unrestricted license to practice medicine from the Country and/or State in which the Service is based
4.3.3.4.2. Five or more years of clinical experience and qualifications in a relevant specialty (e.g. Intensive Care Medicine, Anaesthesia, Emergency Medicine)
4.3.3.5.3. A minimum of 2 years' experience in a critical care environment including also "out of hospital" clinical activity
4.3.3.4.4. Maintenance of clinical currency in an acute medical role
4.3.3.4.5. Full command of the official language(s) of the country in which the Service is based
4.3.3.4.6. A good working knowledge of the English language
4.3.3.4.7. Postgraduate training / qualifications in patient transfer from recognised courses and providers in transfer medicine or aviation medicine
4.3.3.4.8. A thorough understanding of the concepts of safe and effective patient transfer, by ground and air
4.3.3.5. The MD operates within the mission statement and scope of the Service and according to local and international standards
4.3.3.6. The MD demonstrates sound clinical and logistical judgement when planning and undertaking missions

4.3.3.7. The MD practices and promotes the provision of high standards of care for all patients using the Service
4.3.3.8. The Medical Director has other important areas of organisational responsibility which include:
4.3.3.8.1. Responsibility for recruitment, training and Continuous Professional Development for healthcare staff
4.3.3.8.2. Ensuring the continuing competency and currency of medical personnel
4.3.3.8.3. Development and maintenance of guidelines / SOP's relating to specific patient conditions and how they should be managed and digitally available to Medical Crew during patient transfer
4.3.3.8.4. Ensuring the Service has an effective framework of Clinical Governance, including audit, quality improvement, risk and medicines management
4.3.3.8.5. Developing and managing robust processes to identify, document, investigate and resolve adverse clinical events and near-misses, in order to improve patient safety and quality of care
4.3.3.8.6. Chairs regular Medical Department Governance / Quality meetings with the aim of improving patient care and service delivery.
4.3.4. Clinical Services Manager (if applicable)
4.3.4.1. The Service may employ, if applicable, in addition to the Medical Director, a Clinical Services Manager (CSM), who may be a Flight Nurse Manager
4.3.4.2. The CSM shall have knowledge and experience in both air and ground patient transport, depending upon the scope of the service and reports to the Medical Director
4.3.4.3.The CSM maintains clinical currency by undertaking regular external work and training in hospitals or clinics
4.3.4.4. The CSM should undertake regular flying duties (at least monthly) in order to maintain an effective service overview and flight currency
4.3.4.5. The role of the Clinical Services Manager shall include responsibility for, or oversight of the following:
4.3.4.5.1. Day-to-day running of the Medical Department
4.3.4.5.2. Oversight of current and planned cases, working with the Medical Director and other key post-holders within the Service
4.3.4.5.4. Clinical case management and appropriate escalation of complex cases to the Medical Director
4.3.4.5.5. Initial screening of completed case documentation, identification of issues for follow-up and reporting to the Medical Director
4.3.4.5.6. Medical Department human resources issues
4.3.4.5.7. Recruiting, interviewing, training records, currency and competency status for Flight Medical Crew
4.3.4.5.8. Maintenance of rotas, availability calendar, and key operability status board(s)
4.3.4.5.9. Stock management and procurement of:
4.3.4.5.9.1. Medicines
4.3.4.5.9.2. Medical equipment
4.3.4.5.9.3. Medical consumables
4.3.4.5.9.4. Portable oxygen concentrator (including batteries)
4.3.4.5.10. Restocking / management of medical equipment and pharmacy bags/stores following each mission
4.3.4.5.11. Management of contracts for external service providers in areas including:
4.3.4.5.11.1. Cleaning and disinfection of medical equipment
4.3.4.5.11.2. Waste and sharps disposal including witnessing and recording of disposal of controlled substances
4.3.4.5.11.3. Medical equipment servicing
4.3.4.5.11.4. Issuing of uniforms and appropriate personal protective equipment to Flight Medical Crew (uniforms and PPE to be separate)

4.3.4.5.12. Additional Clinical Services Manager duties may be shared with the Medical Director, and may include:
4.3.4.5.12.1. Reviewing and updating of Medical SOP's and Guidelines
4.3.4.5.12.2. Recruitment, training and Continuous Professional Development for non-physician medical personnel
4.3.4.5.12.3. Clinical and logistical decisions and advice regarding patient care
4.3.4.5.12.4. Daily allocation of Flight Medical Crew to missions, based on clinical need and risk analysis
4.3.4.5.12.5. Active involvement in Clinical Governance and Quality Improvement programs
4.3.4.5.12.6. Oversight of mission documentation, including medical reports, briefing notes and handover forms
4.3.4.5.12.7. Medical planning and prioritisation in conjunction with the Medical Director
4.3.5. Clinical Coordinators (when used by the Service)
4.3.5.1. May be deputized to perform any duties of the Clinical Services Manager
4.3.6. Flight Doctors
4.3.6.1. All Flight Doctors employed by the Service shall comply with the following criteria:
4.3.6.1.1. Hold a current and unrestricted licence to practice medicine in a relevant specialty e.g. anaesthesia, intensive care medicine, emergency medicine from the country in which the Service is based
4.3.6.1.2. For Advanced Care mission there should be at least 3 years experience in a relevant medical role e.g. Intensive Care, Anaesthesia or Emergency Department nursing
4.3.6.1.3. Maintains clinical currency in a relevant medical role on at least a monthly basis
4.3.6.1.4. Has full command of the official language of the country in which the Service is based
4.3.6.1.5. Has a good working knowledge of the English language if the Service is operating internationally
4.3.6.2. Specific points when the Service uses temporary Flight Doctors:
4.3.6.2.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.6.2.2. They should provide clinical care to a level that matches or exceeds the permanent medical staff
4.3.6.2.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine
4.3.6.2.4. Corporate indemnity insurance should cover the temporary Flight Doctors roles
4.3.6.3. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director
4.3.7. Flight Nurses
4.3.7.1. Each Flight Nurse meets national regulatory criteria for employment as a qualified and registered Nurse
4.3.7.2. Each Flight Nurse is trained by the Service and is familiar with Service's policies and procedures
4.3.7.3. For Advanced Care mission there should be at least 3 years experience in a relevant nursing role e.g. Intensive Care, Anaesthesia or Emergency Department nursing
4.3.7.4. Flight Nurses undertake regular Continuous Professional Development relevant to the Flight Nurse role
4.3.7.5. Specific points when the Service uses temporary Flight Nurses
4.3.7.5.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.7.5.2. They should provide clinical care to a level that matches or exceeds the permanent medical staff

4.3.7.5.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine
4.3.7.5.4. Corporate indemnity insurance should cover the temporary Flight Nurses roles
4.3.7.6. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director
4.3.8. Flight Paramedics
4.3.8.1. Flight Paramedics must meet the essential national regulatory criteria for employment as a qualified and registered paramedic
4.3.8.2. Each Flight Paramedic is trained by the Service and is familiar with Service's policies and procedures
4.3.8.3. For Advanced Care mission there should be at least 3 years experience as a front line Paramedic
4.3.8.4. Flight Paramedics undertake regular Continuous Professional Development relevant to the Flight Paramedic role
4.3.8.5. Specific points when the Service uses temporary Flight Paramedics
4.3.8.5.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.8.5.2. They should provide clinical care to a level that matches or exceeds the permanent medical staff
4.3.8.5.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine
4.3.8.5.4. Corporate indemnity insurance should cover the temporary Flight Paramedics roles
4.3.8.6. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director
4.3.9. Flight Allied Healthcare Professionals (AHP's) - i.e. non-nurse, non-physician roles such as Respiratory Technician, Midwife, Physiotherapist
4.3.9.1. Flight AHP's must meet the essential national regulatory criteria for employment in their specialty
4.3.9.2. There must be evidence of a clear legal or regulatory framework to support the use of AHP's in patient transfer
4.3.9.3. Each Flight AHP is trained by the Service and is familiar with Service's policies and procedures
4.3.9.4. For Advanced Care mission there should be at least 3 years experience in the field of specialty
4.3.9.5. Flight AHP's undertake regular Continuous Professional Development relevant to their role
4.3.9.6. AHP's should receive the equivalent induction training, and CPD to the regular Flight Medical Crew
4.3.9.7. Specific points when the Service uses temporary Flight AHP:
4.3.9.7.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.9.7.2. They should provide clinical care to a level that matches or exceeds the permanent medical staff
4.3.9.7.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine
4.3.9.7.4. Corporate indemnity insurance should cover the temporary Flight AHP roles
4.3.9.8. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director
4.3.10. Flight Specialist Personnel (e.g. Pediatric, Neonatal, Cardiac Perfusionists, ECMO and Balloon Pump Specialists)
4.3.10.1. Specialist Personnel may be employed or sub-contracted for specialised transfers and should meet the following criteria
4.3.10.1.1. Compliance with national licence, registration and/or certification requirements of the country in which the Service is based.
4.3.10.1.2. Be in possession of recognised specialist knowledge and skills, relevant to the specific mission
4.3.10.1.3. Specialist Personnel should receive equivalent Induction Training and Continuous Professional Development, or be directly supervised by a regular member of Flight Medical Crew during missions

4.3.10.2. For Advanced Care mission there should be at least 3 years experience in the field of specialty
4.3.10.3. Specific points when the Service uses temporary Flight Specialist Personnel
4.3.10.3.1. They should be trained by the Service and be familiar with Service's policies and procedures
4.3.10.3.2. They should provide clinical care to a level that matches or exceeds the permanent medical staff
4.3.10.3.3. They should be provided with the required knowledge, skills and attitudes, awareness of the key regulations and policy documents governing aviation medicine
4.3.10.3.4. Corporate indemnity insurance should cover the temporary Flight Specialist Personnel roles
4.3.10.4. There is documentary evidence that clinical competency in the relevant fields has been achieved, according to standards set by the Medical Director
4.3.11. Security Escort
4.3.11.1. Service will have a dedicated procedure for the use of Security Escort specifying the required conditions when their activation
4.3.11.2. Service will have a dedicated procedure describing which country or situation requires a security support
4.3.11.3. Service will have a dedicated procedure describing what type of security support is required for patient and medical team safety
4.3.12. Training Manager
4.3.12.1. A Training Manager (can be Medical Director and/or Clinical Service Manager) should be responsible for the content and delivery of the Service's training
4.4 Medical Department - Documentation and Patient Records
4.4.1. Evidence must be provided that preparation for transport is based on a patient medical report, assessment of medical equipment and supplies needed, as well as the logistics and geography of the mission under the full authority of Medical Director
4.4.2 Evidence shall also be provided that preparation for transport is based on a clinical and logistic risk analysis prior mission departure
4.4.2.1. Fit to Fly documentation or Risk Assessment documentation
4.4.2.2. Consent form signed by patient or Next of Kin
4.4.3. Patient care records, meeting minutes and policies / procedures are stored according to the Service´s Information Governance Policy and due respect is given to patient-sensitive and confidential information
4.4.4. Patient care records will be securely stored for the minimum period of time, as defined by local regulations
4.4.5. A copy of the patient care record is handed-over to the receiving facility or home address for appropriate continuity of care. Receiving Doctor/Nurse or Next of Kin must sign patient care record to confirm handover (date/time/signature)
4.4.6. If the Service uses an electronic patient record system, a paper-copy (or email) of the patient transfer record is given to the receiving facility at handover. Handover is confirmed by an electronic or physical signature from the receiving team
4.4.7. A Mission Case File is constructed for every mission (may be paper or electronic) and should include
4.4.7.1. Requesting organisation, with corresponding date and time of the request
4.4.7.2. Patient demographics including Patient's first name, last name, date of birth, height, weight, and recumbent measurements to ensure stretcher and loading device suitability
4.4.7.3. The clinical and social status of the patient and any traveling companions
4.4.7.4. The patient's geographical location with details of the sending and receiving healthcare facilities
4.4.7.5. The planned modes of transportation including ground and commercial flights and the details of any third party providers

4.4.7.6. Communications log between provider and transferring facility to obtain a history of events and up to date clinical report prior to clinical team departure
4.4.8. The mission case file should be easily accessible to the Flight Medical Crew prior to and during the mission
4.4.9. A Patient Transfer Record is completed during every mission (paper or electronic) and should include
4.4.9.1. Flight Medical Crew Identifiers and professions / seniority
4.4.9.3. Purpose of the transport
4.4.9.4. Important event timings e.g. take-off, and landing times, arrival times and timing of clinical events
4.4.9.5. Clinical assessment of the patient prior to departure from point of origin
4.4.9.6. Patient condition at predetermined time intervals during the transfer (including documentation of vital signs) - the frequency of observations is appropriate for the condition of the patient
4.4.9.7. Any treatments given or medical interventions made and the patient's response to the treatment
4.4.9.8. Transport modalities for all stages of the transfer
4.4.9.9. Details of the sending and receiving medical teams and confirmation of receipt of clinical handover
4.4.10. The completed Patient Transfer Record is summarised, the data from which is used to maintain a database of missions used for Clinical Governance
4.5. Medical Department - Clinical Policies, Procedures and Guidelines
4.5.1. There are provider-specific medical policies, guidelines and procedures supporting the delivery of high quality care and immediately available to all staff
4.5.2. The service must provide evidence of policy defining limitations in accepting Advanced Care transport in commercial flight based on a risk-benefit analysis for the patient, crew, passengers
4.5.3. Policies are dated and signed by Medical Director
4.5.4. Policies are reviewed and updated (where needed) annually by Medical Director
4.5.5. There are policies on the management of specific clinical conditions that are commonly encountered by the Service
4.5.6. There is a policy on when / how to escalate a case during the quotation / planning phase for Medical Director input
4.5.7. Specific policies (or policy sections within a manual) should be in place for:
4.5.7.1. Medical risk identification, management and mitigation
4.5.7.2. Pre-mission preparation and planning including evidence that clinical staff understand the mission statement / scope of care and that they are involved in clinical decision making when planning the mission
4.5.7.3. Initial patient assessment and preparation for flight / transfer
4.5.7.4. In-flight medical interventions / capabilities
4.5.7.5. Patient handover with duly documents signed
4.5.7.6. Medico-legal aspects of international transfers (e.g. movement narcotics / medicines management and physician licence to practice)
4.5.7.7. Management of traveling companions
4.5.7.8. Guidelines for palliative / end of life transfers (if undertaken)
4.5.7.9. Continuity of patient care on long haul missions and during aircraft delays / technical issues
4.5.7.10. Transportation of patients with psychiatric or mental health conditions (see below specific section 4.16.3.)

4.5.7.11. Venous thromboembolism risk assessment and prophylaxis
4.5.7.12. Pressure area assessment, prophylaxis and treatment
4.5.7.13. Guidelines for patient transport documentation / electronic patient record completion
4.5.7.14. A generic Infection Control policy, which should include
4.5.7.14.1. Procedures for patients with infectious diseases, such as barrier nursing and post-mission disinfection
4.5.7.14.2. The use of PPE, such as masks and gloves along with effective hand hygiene
4.5.7.14.3. Disposal of sharps and clinical waste
4.5.7.14.4. Single use consumables where possible and procedures for effective disinfection & sterilisation for multi-use items
4.5.7.14.5. Cleaning and disinfecting of the equipment as well as Crew uniforms
4.5.7.14.6. A dress code for Flight Medical Crew that is appropriate for infection control
4.5.8. Carriage of 'bariatric patients' or patients with larger body sizes must be in place
4.5.8.1. Weight restrictions for seated/stretchers and related systems (such as loading equipment) should be clearly defined
4.5.8.2. Dimensions restrictions for the commercial fight cabin door, stretcher and cabin environment should be clearly defined
4.5.8.3. Specific manual handling procedures (including loading / unloading) should be defined (and trained / practised) when carrying bariatric patients
4.5.8.4. Any specialised equipment for the carriage of bariatric patients should be detailed, maintained to a good quality and all mission flight crew should be proficient in its use : stock or has readily available
4.5.8.5. Ground transportation should be considered and specific ground ambulances with enhanced capability for bariatric transfers should be used when appropriate
4.5.9. In the event of unexpected clinical complications during transfer, there should be:
4.5.9.1. A manual of medical emergencies that might be encountered during flight, that is readily available to Flight Medical Crew during a live mission
4.5.9.2. The manual should include common medical emergencies of the cardiorespiratory systems and how they are managed
4.5.9.3. The manual should include a flowchart that covers
4.5.9.3.1. Immediate Management
4.5.9.3.2. Method of communication with Base / escalation for support and advice
4.5.9.3.3. When to divert or abandon the transfer, if no longer fit to fly (even when patient becomes unstable while on ground awaiting connecting flight)
4.5.9.3.4. The manual should include clear workflows for when normally physician-led procedures (such as lines, drains or other invasive interventions) are delegated to non-physician staff
4.5.9.4. Induction and CPD (Continuous Professional Development) training for Flight Medical Crew Training should support the above policies
4.5.9.5. The Service must demonstrate that proper and adequate debriefing of flight medical teams and individuals is provided by the Service with appropriate preventive/corrective documented actions if necessary
4.6. Medical Department - Human Resources
4.6.1. All Flight Medical Crew must have an unrestricted licence to practice medicine, be registered, certified or permitted to practice according to local law and regulations
4.6.2. During the recruitment process, relevant background checks and 'due diligence' should be performed for all Flight Medical Crew

4.6.3. During the recruitment process, all Flight Medical Crew must meet a minimum 'Person Specification' or a minimum set of educational requirements according to the scope of service and their role within it
4.6.4. All Flight Medical Crew should act in an ethical and moral way, consistent with guidelines set out by the local / national healthcare licensing authority
4.6.5. There should be a company specific code of ethics and conduct for Flight Medical Crew
4.6.6. Flight Medical Crew skill retention is demonstrated via a mission log book and training portfolio kept up-to-date by both the individual and by the Service
4.6.7. All Flight Medical Crew should participate in a minimum number of regular missions in order to retain skills and knowledge. This will depend on the Service's volume of work, but should be defined in a Medical HR Policy
4.6.8. Medical Department - Appraisals and Performance Review:
4.6.8.1. All Medical Department staff have a regular (at least annual) formal appraisal from a manager, which should include a performance review and plan for the next period.
4.6.8.2. All routine appraisals should be formally documented and stored as part of the HR record
4.6.8.3. Extraordinary appraisals may be performed in exceptional circumstances, such as following critical incidents or for 'performance management' when performance falls below the standard expected
4.6.8.4. Any Extraordinary Appraisals or performance management reviews should be documented and kept as part of the HR record
4.7. Medical Department - Occupational Health
4.7.1. The Service has an Occupational Health Policy(s) that address the following issues:
4.7.1.1. Pre-employment due diligence checks should include occupational health screening and immunisation history
4.7.1.2. The Service keeps records on blood borne pathogen exposure incidents, post-exposure follow-up protocols and staff support
4.7.1.3. Employee 'equality and diversity' should always be considered during recruitment of new staff. Staff with additional needs should be treated equitably, within the scope and practicalities of the service
4.7.1.4. During the 'onboarding' process, consideration should be given to any chronic health condition and how the service might accommodate such conditions whilst maintaining a safe and effective environment for staff and patients
4.7.1.5. Each member of Flight Medical Crew should declare themselves physically and mentally fit to fly and to conduct the given mission prior to each mission dispatch
4.7.1.6. Staff should report any health-related issues that negates one Flight Medical Crew from flying or may affect their performance during a mission, such as the use of chronic medication (e.g. sedatives) or a recent history of diving
4.7.1.7. The Service shall have a uniform policy which includes personal protective equipment (PPE) and how this should be used
4.7.1.8. Crew duty-time limitations and breaks for Flight Medical Crew that recognises the issue of crew fatigue and implements appropriate safeguards
4.7.1.9. If appropriate, the use of hearing protection on the ground and in the air in environments experiencing excessive noise, as defined by local laws
4.7.1.10. An absence policy that should include specific guidelines around working during pregnancy or when suffering from acute illnesses such as gastrointestinal upset
4.7.1.11. There should be a policy on (and training for) Manual handling (lifting and loading)
4.7.1.12. There should be a specific drugs and alcohol misuse policy
4.8. Flight Medical Crew Training

4.8.1. There should be a structured Induction Course as part of staff 'on-boarding' and regular Continuous Professional Development at least annually for all Flight Medical Crew
4.8.2. Training should be available to all Flight Medical Crew and a full training record should be kept as part of the individual's HR record
4.8.3. Training is mapped against aeromedical competencies defined by the Clinical Service Manager or Medical Director according to training course content
4.8.4. Completion of training is documented for each member of Flight Medical Crew and is a pre-requisite before undertaking any unsupervised live missions
4.8.5. Attendance and performance at Induction Training and Continuous Professional Development is documented in a training record and forms part of the annual appraisal
4.8.6. Training should be offered with a combination of face to face and online / distance learning, appropriate to the needs of the Service and local healthcare regulation
4.8.7. Induction Training and CPD (or training confirmed via prior education and competency testing) should cover a range of topics including , but not limited to the following:
4.8.7.1.1. General company introduction including company history
4.8.7.1.2. Introduction to the philosophy, capabilities and structure of the Service
4.8.7.1.3. Overview of how a mission should be planned and conducted from quotation to completion
4.8.7.1.4. Overview of company policies, procedures and guidelines and how to access them
4.8.7.1.5. Human factors, Crew Resource Management and Team Working
4.8.7.1.6. The role of Flight Medical Crew: pre-departure, during and post-mission and especially briefing + debriefing as well as specialist expertise required on a case by case basis
4.8.7.1.7. Communication, caring and empathy - the 'soft' skills needed in good aeromedical transportation
4.8.7.1.8. Medical equipment competency checks and corresponding training where necessary
4.8.7.1.9. Commercial aircraft essential safety and performance knowledge, specific to the aircraft type(s) in use
4.8.7.1.10. Personal health and safety in and around the aircraft
4.8.7.1.11. Commercial aircraft emergency procedures
4.8.7.1.12. Survival training if appropriate to local geography and regulations
4.8.7.1.13. Occupational health; Flight Medical Crew fitness to fly and stress + fatigue management
4.8.7.1.14. Clinical Governance, including:
4.8.7.1.14.1. Risk analysis and management
4.8.7.1.14.2. Medical audit followed by preventive/corrective actions under the supervision of relevant Service stakeholders (Medical Director, Clinical Service Manager ...)
4.8.7.1.14.3. Appraisal and CPD
4.8.7.1.14.4. Documentation and incident reporting
4.8.7.1.14.5. Quality improvement programs
4.8.7.2. Clinical Aspects:
4.8.7.2.1. Basic altitude physiology and pathophysiology, physics of the atmosphere, flight environment, hypoxia and hyperventilation, effect of pressure change on the body, barotrauma and sub-atmospheric decompression illness, short duration acceleration, vibration, noise
4.8.7.2.2. Aircraft acceleration / decelearation and the physical forces affecting the patient

4.8.7.2.3. Caring for patients during the transfer and specifically in the aircraft cabin, including limitations of space and equipment
4.8.7.2.4. Use of medical gases in the flight environment, including:
4.8.7.2.4.1. The benefits, limitations and hazards of supplemental oxygen in flight
4.8.7.2.4.2. Different oxygen storage and delivery devices, such as portable oxygen concentrators, WS 120, oxygen cylinders
4.8.7.2.4.3. Calculation of oxygen supply requirements for the whole mission and the addition of adequate reserves
4.8.7.2.5. Specific Clinical Conditions relevant to aeromedical transfer:
4.8.7.2.5.1. Respiratory disease, such as pneumothorax, pulmonary fibrosis and obstructive airways disease
4.8.7.2.5.2. ENT (disorders of the ears, nose and throat) and dental disease
4.8.7.2.5.3. Management of pain during transfer
4.8.7.2.5.4. Psychiatric and other mental health disorders : refer to specific section 4.16.2.
4.8.7.2.5.5. Bowel obstruction and the surgical abdomen including enteral (NG/gastric) tube management
4.8.7.2.5.6. Neurological conditions (i/e seizures)
4.8.8. Induction Training topics are reviewed and refreshed during a programme of CPD, attended by all Flight Medical Crew, at least anually
4.8.9. Specialised transfers such patients on ECMO, balloon pumps and other advanced organ support
4.8.10. Continuous Professional Development includes mission case discussions with learning from clinical and logistical challenges encountered on recent live missions
4.8.11. 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
4.8.12. 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
4.9. Medicines / Pharmaceutical Management
4.9.1. The service must demonstrate compliance with national medicines / pharmaceutical management laws, regulations and procedures
4.9.2. There should be an accountable person, chosen from the Medical Department management with overall responsibility for medicines management
4.9.3. A record should be kept of persons or personnel that have access to pharmacy stores
4.9.4. There should be a pharmacy room or store cupboard which complies with local laws and / or a national regulatory body
4.9.5. For effective control of some medicines (e.g. opioids / narcotics) the service must have a locked cupboard within another locked cupboard or room
4.9.6. The service shall comply with national laws, regulations (if applicable) and recommendations for the storage, carriage, supply and use of controlled drugs.
4.9.7. The Service complies with manufacturers recommendations for the storage, carriage, supply and use of refrigerated medicines / pharmaceuticals
4.9.8. There is a system to ensure that expiration dates are adhered to and checked regularly
4.9.9. There is evidence of accurate stock checking and a record of medicines / pharmaceuticals procurement or Service has it readily available
4.9.10. Evidence of medicines / pharmaceuticals that have been wasted, destroyed or returned unused is suitably recorded
4.9.11. If non-physicians dispense / administer pharmaceuticals, there is evidence that local / national laws and regulations are followed
4.9.12. Medicines / pharmaceuticals within equipment bags are regularly checked and restocked to ensure their completeness and suitability
4.9.13. For remotely based personnel, there is a procedure for monitoring expiration, use and resupply of medicines.

4.10. Medical Gases Management
4.10.1. The service must comply with national and/or local regulations and recommendations concerning medical gases.
4.10.2. There should be an accountable person, chosen from the medical staff, who has overall responsibility for medical gases management.
4.11. Medical Equipment Management
4.11.1. There should be an accountable person who has day-to-day responsibility for medical equipment management
4.11.2. The service must provide a list of all major items of medical equipment including
4.11.2.1. The make and model of each item as well as certification to be used in aeronautic environment
4.11.2.2. Procurement, purchase or rental agreement
4.11.3. Equipment is regularly tested and inspected according to the manufacturer's guidelines and serviced by a qualified person / company
4.11.4. Equipment is stored and charged appropriately, in-line with manufacturer recommendations and local H+S regulations
4.11.5. There are maintenance and servicing records for each major item of medical equipment

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Section 5: Logistics
5.1 Planning
5.1.1. The Service demonstrates decision making processes which ensure the transport mode (such as: commercial airliner, air ambulance or air taxi) is the most appropriate vehicle/method for each patient
5.1.2. The Service demonstrates 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
5.1.3. The Service provides evidence that decisions on transport and carriage modality are based on clinical need and patient safety, and not unduly influenced by price alone
5.1.4. Longer missions / flight times should allow for the Escort to have sufficient rest following patient assessment, prior to commencing the return leg / patient transport
5.2. Mission Crewing and Personnel
5.2.1. A policy on Flight Medical Escort allocation exists which includes:
5.2.1.1. An appropriate level of experience and skill mix are chosen according to the patient's clinical and logistical needs and level of care
5.2.2.2. For long and / or complex missions, two or more escorts are provided to ensure continuity of care and rest breaks
5.3. External Ground Transport Providers
5.3.1. The service shall maintain a database of the capabilities and quality of each external provider and partner which it utilises for the transport of patients
5.3.2. Providers and partners will be audited from time to time in order to maintain quality assurance. Audits should demonstrate:
5.3.2.1. Evidence that care on each mission is optimised by a clear understanding of the capability, quality and safety of the transport provider
5.3.2.2. Equipment supplied by external transport providers is checked and verified - to ensure compatibility, efficacy and condition (e.g. stretchers, oxygen supply and delivery, bedding and hygiene)
5.3.2.3. The Service provides evidence that it is open and transparent in terms of transport risk to the provider. E.g. for patients with mental health disease or high-consequence infectious disease
5.4. External Non-Airline Aircraft Charter
5.4.1. The Service understands its responsibility to ensure quality, capability, and safety when choosing air transport providers
5.4.2. The service shall maintain a database of the capabilities and quality of each external provider and partner which it utilises for the transport of patients
5.4.3. Providers and partners will be audited from time to time in order to maintain quality assurance. Audits should demonstrate:
5.4.3.1. Evidence that care on each mission is optimised by a clear understanding of the capability, quality and safety of the transport provider
5.4.3.2. Equipment supplied by external transport providers is checked and verified - to ensure compatibility, efficacy and condition (e.g. stretchers, oxygen supply and delivery, bedding and hygiene)
5.4.4. The Service provides evidence that it is open and transparent in terms of transport risk to the provider. E.g. for patients with mental health disease or high-consequence infectious disease
5.4.5. The Service shall demonstrate evidence that when it utilises non-airliner aircraft for patient transport, quality and safety is maintained by:

5.4.5.1. Utilising a EURAMI-accredited (or equivalent) air ambulance company as its transport provider wherever possible
5.4.5.2. If a EURAMI accredited (or equivalent) provider is not available in the region, every effort should be made to choose the safest, highest-quality provider possible
5.4.5.3. The Service maintains its overall mission responsibility when using the services of a broker to identify external transport provider
5.5. Airlines and Airline Communication
5.5.1. The service shall provide evidence of the use of MEDIF communications with airlines
5.5.2. 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
5.5.3. Records of discussions with airline medical departments, patient support teams, booking office, and other interested parties shall be kept in the mission file
5.5.4. Where an airline refuses to carry a patient, the mission file shall record the reason(s) for the refusal
5.6. Client-Coordinated Logistics (for missions where the logistics are arranged and coordinated by the client / insurance company)
5.6.1. The Escort's progress is monitored continuously via secure messaging, in order to communicate changes or for the Escort to seek guidance
5.6.2. The full itinerary is known and recorded by the Logistics / Operations staff prior to mission commencement
5.6.3. The Escort is kept appraised of any changes to the itinerary straight away via secure messaging
5.6.4. A dedicated phone line / real-time comms channel exists between the Provider and Client to trouble shoot any issues (e.g. taxi's, hotels) quickly and efficiently
5.7. Safe and Effective Patient Lifting, Loading and Unloading:
5.7.1. The safe loading and unloading of patients must be possible under all operational conditions
5.7.2. Approved manual handling techniques must be practiced by all staff
5.7.3. When other ground handlers, not employed by the Service, are utilised to assist with lifting, the Escort takes a lead-role to ensure patient safety
5.7.4. The loading procedure must ensure that the patient's position remains horizontal or seated (as appropriate)
5.7.5. The Service must have a policy on the management of bariatric patients, including:
5.7.5.1. The correct processes for loading unloading and restraint
5.7.5.2. Details of weight and dimensional limitations beyond which a bariatric patient will be refused carriage
5.7.6. Continuous monitoring of vital signs must be maintained through the loading / unloading process
5.7.7. The Escort(s) must retain access to the patient during all stages of loading and unloading
5.8. Hotels and Subsistence
5.8.1. A database of appropriate hotels is kept and regularly updated based on mission feedback
5.8.2. Hotels at the transferring location are chosen based on:
5.8.2.1. Accessibility to the patient and to the airport
5.8.2.2. Appropriate check-in / check-out times
5.8.2.3. Must be of sufficient quality to allow the Escort to have effective rest (e.g. away from noise and light pollution whenever possible)

5.8.2.4. Must have on-site catering 24 hours, or alternative provision for the Escort's welfare needs must have been organised prior to mission commencement
5.8.2.5. Feedback on the quality of accommodation is sought and poorly performing facilities are removed from the database
5.9. Check-in and Security
5.9.1. There is a policy and training materials on airport security and the check-in process for Escorts with medical equipment
5.9.2. Prior clearance is sought from the airline where appropriate for carriage of medical equipment (e.g. medical bags and oxygen concentrator)
5.9.3. Documentation is provided to the Escort that may be given to Security explaining the purpose of the medical kit and mission
5.10. Medical Equipment Logistics and Stowage
5.10.1. There should be a policy detailing how medical bags are transported to the Escort and back to the Service, if the Escort lives remote from Base
5.10.2. The full contents of each medical bag should be listed on an inventory sheet that can be checked at Security if required
5.10.3. There is a method (and policy) for the Escort to record what equipment and consumables have been used on this mission for the purposes of stock control
5.10.4. There should be a policy on how and where medical equipment is stored on a mission. This should include:
5.10.5. Equipment and medication is kept with the escort and under their direct supervision at all times wherever possible
5.10.6. If medical equipment and medication needs to be kept away from the escort (e.g. during meal times at the hotel), it should be in a secure, locked area where the risk of unathorised access is minimised