DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Public Health
Emergency Medical Services

4302 Air Medical Ambulance Service

1.0 Purpose and General Provisions

1.1 Purpose. The purpose of this regulation is to provide minimum standards for the operation of air medical ambulance services in the State of Delaware. It is the further intent of this regulation to ensure that patients are quickly and safely served with a high standard of care and in a cost-effective manner.

1.2 General Provisions

1.2.1 No governmental or private person or agency may operate, conduct, maintain, advertise, engage in, or profess to engage in air medical ambulance services in Delaware unless the person or agency holds a current valid certificate issued by the Division.

1.2.2 Air medical ambulance services must provide access to its services without discrimination due to race, creed, sex, color, age, religion, national origin, ancestry, or disability. Requests for air medical ambulance service for patients with a potentially life-threatening illness or injury, who require rapid transportation, will be honored without prior inquiry regarding the patient's ability to pay.

1.2.3 Out-of-state air medical ambulance services that provide 'point to point' air medical ambulance transport services within the State of Delaware shall be subject to this entire regulation (full certification) unless covered by mutual aid agreements entered with a State of Delaware agency, in conjunction with other applicable state laws.

1.2.4 All air medical ambulance services with a base of operations located within the State of Delaware, or that engage in providing prehospital 911 service regardless of the location of their base of operations, will be subject to this entire regulation (full certification).

1.2.5 Pre-hospital scene work shall be conducted only by air medical ambulance services owned and operated by the State of Delaware, or private air medical ambulance services which have entered into appropriate agreements with the Division of Public Health and Delaware State Police to provide air medical ambulance services.

1.2.6 All out-of-state air medical ambulance service flight programs that only provide services consisting of one-way transports either into or out of Delaware, are subject to this entire regulation for certification of the Flight Program. Air medical ambulance service personnel may maintain appropriate licensure or certification in their home state, in lieu of seeking Delaware licensure/certification (limited certification).

4 DE Reg. 1827 (5/1/01)
5 DE Reg. 1727 (3/1/02)
29 DE Reg. 411 (11/01/25)

2.0 Definitions

The following words and terms, when used in this regulation, have the following meaning:

"**ABEM**" means the American Board of Emergency Medicine.

"**ABOEM**" means the American Board of Osteopathic Emergency Medicine.

"**Advanced cardiac life support**" or "**ACLS**" means a certification of the American Heart Association (AHA) that refers to a set of clinical interventions and algorithms used to manage and treat cardiac emergencies, including cardiac arrest, stroke, and acute coronary syndromes.

"**Advanced life support**" or "**ALS**" means the advanced level of prehospital and interhospital health care that includes basic life support functions plus cardiac monitoring, cardiac defibrillation, electrocardiography, administration of anti-arrhythmic agents, intravenous therapy, administration of specific medications, drugs, and solutions, use of adjunctive medical devices, trauma care, and other authorized treatments and procedures.

"**Advanced trauma life Support**" or "**ATLS**" means a syllabus and certification offered to physicians by the American College of Surgeons in the management of acute trauma cases.

"**Air medical ambulance service**" means a company or entity of a hospital or public service that provides air medical ambulance transportation to patients requiring medical care.

"**Air medical personnel**" means the patient care personnel involved in an air medical ambulance transport.

"**Air medical team**" means the pilot or pilots and patient care personnel who are involved in an air medical ambulance service transport.

"**Aircraft type**" means a specific make and model of helicopter or airplane.

"**ALS mission**" means the transport of a patient who receives care during an interfacility or scene response commensurate with the scope of practice of an EMT-Paramedic.

"**ALS provider**" means a certified provider of skills required for advanced life support.

"**Base of operations**" means a location from which an air medical ambulance aircraft responds to a call and to which it returns while awaiting assignment to another call.

"**Basic life support**" or "**BLS**" means the level of capability which provides EMT emergency patient care designed to optimize the patient's chances of surviving a medical emergency.

"**BLS provider**" means a certified provider of skills required for basic life support.

"**Certificate**" means a pilot level of competency, e.g., student, private, or commercial. "Certificate" can also refer to the type of air medical ambulance service a company is qualified to provide under Federal Aviation Administration regulations.

"**Consortium program**" means an air medical ambulance service sponsored by more than 1 health care facility or entity.

"**Continuous quality improvement**" or "**CQI**" means a management strategy that integrates dedication to a quality product into every aspect of the patient care service, bringing together a variety of personnel and management tools to examine the sources of problems within the interfacility system.

"**Cross country**" or "**CC**" means when the destination is greater than 25 nautical miles from the departure point or as designated by a geographic boundary. The Delaware State Police definition of cross country is 25 nautical miles outside of the State of Delaware.

"**DSP**" means the Delaware State Police.

"Director" means the Delaware Department of Health and Social Services, Director of the Division of Public Health.

"**Division**" means the Delaware Department of Health and Social Services, Division of Public Health.

"**Emergency locator transmitter**" or "**ELT**" means a radio device that transmits distress signals when an aircraft crashes or experiences a significant impact.

"**EPCR**" means Electronic Patient Care Report.

"**FAA**" means the Federal Aviation Administration.

"**FAR**" means the Federal Aviation Administration Regulation.

"**Head-strike envelope**" means the volume of air space which a person's head would potentially move through during any abrupt aircraft motion.

"**Helipad**" means a small, designated area, usually a prepared surface in an airport landing/take-off area, or apron/ramp used for take-off, landing, or parking helicopters.

"**Hot load/unload**" means the loading or unloading of a patient, patients, or equipment from a helicopter with rotors turning.

"**IFR**" means instrument flight rules.

"**IMC**" means instrument meteorological conditions.

"**Infection control**" means an approach to reducing the risk of disease transmission to caretakers, patients, and others.

"**Modalities**" means treatment plans and equipment used in the delivery of patient care.

"**Mutual aid agreements**" means the establishment of appropriate arrangements with EMS systems of other jurisdictions for the provision of emergency medical services on a reciprocal basis.

"**Office**" or "**OEMS**" means the Delaware Division of Public Health, Office of Emergency Medical Services.

"**Paramedic**" or "**EMT-P**" means a person who: has successfully completed a course approved by the Delaware Board of Medical Licensure and Discipline or its duly authorized representative; is documented by OEMS; and is recognized by the Delaware State Fire Commission as a Delaware EMT while in the performance of their professional duties with a county paramedic service or State agency.

"**PIC**" means pilot in command.

"**Point to point transport**" means an air medical ambulance service transport that has both an origination and destination point within the State of Delaware.

"**Prehospital 911 service**" means a service which acts as a supplemental resource to the Delaware State Police in carrying out prehospital scene missions.

"**Prehospital trauma life support**" or "**PHTLS**" means a course offered by the American College of Surgeons to provide a standard of care for the prehospital trauma victim.

"**Quality assurance**" or "**QA**" means a process of reviewing the quality of patient care delivered through the examination of known or potential problems. Quality assurance measures the degree of compliance of the air medial ambulance service's personnel with established standards.

"**Specialty care mission**" means the air medical ambulance service's transport of a patient who requires care by professionals that can be added to the list of regularly scheduled personnel.

"**Specialty care provider**" means a provider of specialty care, such as neonatal, pediatric, etc.

"**VFR**" means visual flight rules.

29 DE Reg. 411 (11/01/25)

3.0 Application Process

3.1 An application for a certificate to operate an air medical ambulance service may be obtained from the OEMS. An application for an original or renewal certificate shall be submitted to the Office and shall include the following:

3.1.1 The name and address of the air medical ambulance service vendor or proposed air medical ambulance service vendor, and the name and address under which the service will operate.

3.1.2 The name, address, and FAA certification number of the aircraft operator.

3.1.3 The air medical ambulance service's mission statement and scope of service to be provided.

3.1.4 The experience and qualifications of the applicant to operate an air medical ambulance service.

3.1.5 The description of each aircraft to be used as an air medical ambulance, including the make, model, year of manufacture, registration number, name, monogram, or other distinguishing designation, and FAA air worthiness certification.

3.1.6 The geographical service area, location, and description of the places from which the air medical ambulance service is to operate.

3.1.7 The name, training, and qualifications of the air medical ambulance medical director who is responsible for medical care provided by the service.

3.1.8 The roster of medical personnel, which includes the level of Delaware certification or licensure.

3.1.9 The roster of pilots, including training and qualifications.

3.1.10 A statement in which the applicant agrees to provide patient-specific data to the Division for Emergency Medical Service system quality management program purposes.

3.1.11 Other information the Division deems necessary and prescribes as part of the application.

3.2 Change of ownership of the air medical ambulance service requires re-application for certification. An air medical ambulance certificate holder shall file with the Division an application for renewal of the air medical ambulance service certificate within 10 business days of acquisition of the service by the new owner.

4 DE Reg. 1827 (5/1/01)

29 DE Reg. 411 (11/01/25)

4.0 Certification Process

4.1 Within 30 days of receipt of a fully completed application from the proposed air medical ambulance service, the Office will notify the applicant in writing of the approval or disapproval of the application.

4.2 Certification Approval

4.2.1 The Division will issue a certificate to operate an air medical ambulance service. The OEMS may conduct an on-site inspection to confirm that the applicant service is in compliance with this regulation and other applicable laws.

4.2.2 No certificate to operate an air medical ambulance service shall be issued unless the applicant provides evidence to the Division that the certification requirements for the air medical ambulance, medical supplies, and equipment, as well as the qualifications of medical and operating personnel, as discussed herein, have been satisfied.

4.2.3 Certification will be granted only to services that meet all Federal Aviation Regulations (FARs) specific to the operations of the air medical ambulance service.

4.2.4 A certificate will be issued for 3 years from the date of issue and will remain valid for that period unless revoked or suspended by the Division.

4.2.5 The current certificate shall be posted in a conspicuous place in the air medical ambulance operations center and on, or in, the aircraft where it is clearly visible.

4.3 Denial of Certification

4.3.1 If the Division determines that deficiencies exist which warrant denial of the application, the air medical ambulance service shall be provided a written list of the deficiencies.

4.3.2 The applicant shall have 30 days from receipt of the denial notice in which to respond to the Division with plans to correct the deficiencies.

4.3.2.1 After review of an acceptable plan, the Division will conduct a re-inspection consistent with an agreed upon time frame.

4.3.2.2 If the Division is satisfied with the results of the re-inspection, the Division will promptly issue a certificate of approval. If the Division determines that deficiencies still exist, the Division will give the applicant written notice of disapproval, which shall identify deficiencies. The applicant shall have 30 days from receipt of the second refusal notice in which to request a review of

their application and accompanying documents by the Director or the Director's designee. If the result is a denial of application, the applicant may not reapply for a period of 6 months.

4.4 Renewal of Certification

4.4.1 The air medical ambulance service shall submit to the Division the renewal application postmarked at least 60 days prior to the expiration date of the certificate.

4.4.2 The criteria for certification renewal are the same as the current requirements for original certification.

4.5 Inspections

4.5.1 The Division reserves the right to enter and make inspections. All services applying to provide prehospital 911 service will, at a minimum, have an initial inspection prior to execution of the required Memorandum of Agreement allowing them to commence prehospital operations.

4.5.2 Upon request of an agent of the Division during regular business hours, or at other times when a reasonable belief that violations of this regulation may exist, a certificate holder shall produce for inspection, the air medical ambulance, equipment, personnel, and other such items as is determined by the Division's agent.

4.5.3 All records pertaining to the operation of the air medical ambulance service must be retained for a minimum of 2 years.

4.6 Investigatory Procedures. Upon receipt of a written complaint describing specific violations of this regulation, the Division will:

4.6.1 Initiate an investigation of the specific charges;

4.6.2 Notify the air medical ambulance service of the charges and investigation procedures;

4.6.3 Conduct and develop a written report of the investigation;

4.6.4 Notify the air medical ambulance service in writing of the results of the investigation with a request for a written response; and

4.6.5 Conduct an appropriate follow-up investigation.

4.7 Grounds for Suspension, Revocation, or Refusal of an Air Medical Ambulance Service Certification

4.7.1 The Division may, in compliance with proper administrative procedure as provided by law, suspend, revoke, or refuse to issue certificates for the following reasons:

4.7.1.1 A serious violation of this regulation that poses a significant threat to the health and safety of the public.

4.7.1.2 Failure of the certified party or applicant to submit a plan to the Division to correct deficiencies and violations cited by the Division by the deadline requested by the Division.

The plan must correct the deficiencies within the timeframe specified by the Division.

4.7.1.3 The existence of a pattern of deficiencies or violations over a period of 3 or more years.

4.7.1.4 Fraud or deceit in obtaining or attempting to obtain certification.

4.7.1.5 Lending a certificate, borrowing, or using the certificate of another air medical ambulance service, or knowingly aiding or abetting the improper granting of a certificate.

4.7.1.6 Incompetence, negligence, or misconduct in operating the air medical ambulance service, or in providing emergency medical services (EMS) to patients.

4.7.1.7 Failure to employ or contract for a medical director responsible for the care provided by the air medical ambulance service.

4.7.1.8 Failure to have appropriate medical equipment and supplies required for certification.

4.7.1.9 Failure to have an aircraft equipped in compliance with this regulation.

4.7.1.10 Failure of the aircraft operator to maintain required FAA certifications.

4.7.1.11 Failure to employ enough certified or licensed personnel to provide services during the time frames identified in the application and approved certification.

4.7.1.12 Failure to be available during periods specified upon in the approved certification. Exceptions to this requirement include:

4.7.1.12.1 Unsafe weather conditions;

4.7.1.12.2 Commitment to another flight;

4.7.1.12.3 Grounding due to maintenance, or other reasons that would prevent commitment to another flight; or

4.7.1.12.4 Other reasons that would prevent response.

4.7.1.12.4.1 The air medical ambulance service shall maintain a record of each failure to respond to a request for service and make the record available upon request to the Division.

4.7.1.12.4.2 Financial inability of a patient to pay does not constitute sufficient grounds to deny response for emergency air service.

4.7.1.13 Failure of an air medical ambulance service to notify the Division of the change of ownership or aircraft operation.

4.7.1.14 Abuse or abandonment of a patient.

4.7.1.15 Unauthorized disclosure of medical or other confidential information.

4.7.1.16 Willful preparation or filing of false medical reports or records, or the inducement of another to do so.

4.7.1.17 Destruction of medical records.

4.7.1.18 Refusal to render emergency medical services because of a patient's race, sex, creed, national origin, sexual orientation, age, disability, medical issue, or the patient's financial inability to pay.

4.7.1.19 Misuse or misappropriation of drugs or medications.

4.7.1.20 Failure to produce requested records for inspection or to permit examination of equipment and facilities shall be grounds for suspension, revocation, or denial of certification. No certificate shall be suspended, revoked, or denied for a period not to exceed 60 days in the event that a dispute regarding the production of the records exists and remains unresolved, except that the suspension or revocation may occur within the 60-day period if the Division determines that the action is necessary to prevent a clear and immediate danger to public health.

4.7.1.21 Other reasons as determined by the Division which pose a significant threat to the health and safety of the public.

4.7.2 If the Division determines an air medical ambulance service is non-compliant with this regulation, the Division may:

4.7.2.1 Place the air medical ambulance service on probation until the deficiency is remedied and approved by the Division.

4.7.2.1.1 This probation will include a timeframe and method by which the service must demonstrate the deficiency or violation has been rectified.

4.7.2.1.2 If an air medical ambulance service is unable to demonstrate that the deficiency or violation has been rectified within the specified timeframe, it must submit a written progress report to the Director requesting a deadline extension.

4.7.2.1.2.1 Failure to comply will result in the 'Probation' status being changed to 'Suspension'.

4.7.2.1.2.2 Failure to correct the deficiencies or violations within the extension period will result in suspension of the certificate.

4.7.2.2 Suspend certification for a period of up to 30 days.

4.7.2.2.1 In circumstances where an alleged violation poses an immediate threat to public health is being investigated, the certification may be suspended during the investigation.

4.7.2.2.2 The Division must investigate the violation and issue a written report containing the findings of the investigation

4.7.2.2.2.1 The report must describe the deficiencies or violations that must be corrected to reinstate certification.

4.7.2.2.2.2 A hearing must be scheduled within 30 days of the date of suspension.

4.7.2.2.3 Upon suspension or revocation of an air medical ambulance certificate, the service shall cease operations, and no person may permit or cause the service to continue.

4.7.2.2.4 The air medical ambulance service must correct any deficiencies identified to be an immediate danger to public health within the suspension period.

4.7.2.2.4.1 All other deficiencies or violations may be addressed in a correction plan submitted to the Division.

4.7.2.2.4.2 The status of the air medical ambulance service certificate will be changed to 'Provisional' for implementation of the corrective plan.

4.7.2.3 Revoke certification.

4.7.2.3.1 Violations or deficiencies that resulted in a 'Suspension' status and have not been rectified pursuant to the requirements of this regulation will result in the revocation of the air medical ambulance service's certificate.

4.7.2.3.2 A hearing will be scheduled within 30 days of the date of revocation.

4.7.2.4 Continue current certificate status.

4.7.2.5 The Division will provide public notification of their decisions involving probation, suspension-including the length of suspension period, or revocation of an air medical ambulance service certificate.

4.8 Reinstatement Process

4.8.1 When an air medical ambulance service has corrected a problem that has resulted in suspension or revocation of their certificate, the service shall notify the Division of Public Health in writing, requesting reinstatement.

4.8.2 Based on the recommendations of the Division, a review will be arranged to verify resolution of the problem.

4.8.3 Outcomes of the review will be:

4.8.3.1 Reinstatement of certification; or

4.8.3.2 Continuation of suspension or revocation.

4.9 Right of Appeal

4.9.1 Any air medical ambulance service that has had its reapplication for certification denied, or certification revoked or suspended, may appeal the decision.

4.9.2 Written notification of the intent to appeal must be received by the Director within 30 days of receipt of notice of such denial, suspension, or revocation.

4.9.3 The Director or the Director's designee will conduct a hearing on the Division's action.

4.9.4 Information pertinent to the case will be presented by a member of the Division's investigation committee (or the OEMS), and a representative of the air medical ambulance service.

4.9.5 The hearing panel will make a recommendation to the Director that the decision stand, be reversed, or modified. Specific recommendation for modification shall be outlined.

4.9.6 The Director will decide based on the hearing panel's recommendations and will provide written notification of the action to the air medical ambulance service.

4.9.7 The Division's action shall not be automatically stayed during the pendency of the appeal.

4.10 Voluntary Discontinuation of Service

4.10.1 Certified air medical ambulance services may not voluntarily discontinue service until 90 days after the certificate holder notifies the Division in writing that the service is to be discontinued.

4.10.2 The air medical ambulance service shall notify the Division in advance of anticipated temporary discontinuation of service expected to last at least 7 consecutive days.

4 DE Reg. 1827 (5/1/01)
5 DE Reg. 1727 (3/1/02)
29 DE Reg. 411 (11/01/25)

5.0 Staffing

5.1 Air Medical Personnel Classifications. The aircraft, by virtue of medical staffing and retrofitting of medical equipment, becomes a patient care unit specific to the needs of the patient. Staffing shall be commensurate with the mission statement and scope of care of the air medical ambulance service.

5.1.1 Administrative Air Medical Ambulance Service Staff

5.1.1.1 Medical Director. The medical director of the program is a physician who is responsible for supervising and evaluating the quality of medical care provided by the air medical personnel.

5.1.1.1.1 Credentials/Experience

5.1.1.1.1.1 The medical director shall be licensed and authorized to practice medicine in the state in which the air medical ambulance service is based, unless the flight program is providing primary 911 or 'point to point' transfer services in the State of Delaware. If either of these services are provided, the physician must be licensed in Delaware. The medical director must have educational and clinical experiences in emergency medicine, as well as other areas of medicine that are commensurate with the mission statement of the air medical ambulance service (e.g., adult trauma, pediatrics, neonatal transport, etc.). When specific missions fall outside the scope of expertise of the medical director, specialty care physicians must serve as consultants.

5.1.1.1.1.2 The medical director shall be experienced in both air and ground emergency medical services (as appropriate to the mission statement) and be familiar with the general concepts of appropriate utilization of air medical ambulance services.

5.1.1.1.1.3 Additionally, the medical director shall have the following educational experiences as appropriate to the mission statement and scope of care of the air medical ambulance service:

5.1.1.1.1.3.1 Specialty education consistent with the mission statement of the air medical ambulance service (e.g., Neonatal Resuscitation Certification Program, Pediatric Advanced Life Support Certification, etc., or equivalent education in these areas). Alternately, the medical director must have immediate access to specialty physicians as consultants.

5.1.1.1.1.3.2 In-flight patient care capabilities and limitations (e.g., assessment and invasive procedures).

5.1.1.1.1.3.3 Infection control as it relates to prehospital, aircraft, and the hospital environment.

5.1.1.1.1.3.4 Stress recognition and management.

5.1.1.1.1.3.5 Altitude physiology/stressors of flight.

5.1.1.1.2 General Areas of Responsibility

5.1.1.1.2.1 The medical director must be actively involved in the quality assurance/continuous quality improvement (QA/CQI) program for the air medical ambulance service.

5.1.1.1.2.2 The medical director must be involved in administrative decisions affecting medical care for the air medical ambulance service.

5.1.1.1.2.3 The medical director must be involved in training and continuing education of all air medical personnel for the air medical ambulance service.

5.1.1.1.2.4 The medical director must be actively involved in the care of critically ill or injured patients.

5.1.1.1.2.5 The medical director must be actively involved in orienting physicians providing online (in-flight) medical direction to the policies, procedures, and patient care protocols of the air medical ambulance service.

5.1.1.1.2.6 When applicable, the medical director or the medical director’s designee sets cabin air pressure altitude limits, for specific disease processes of the patient or patients (through policies and procedures) and maximum altitudes, for specific disease processes of the patient or patients for rotor wing transports.

5.1.1.2 Clinical Care Supervisor. The responsibility for supervision of patient care provided by the various clinical care providers (e.g., EMT-B, EMT-P, RN, etc.) will be the responsibility of the medical director, unless the responsibilities are assigned to another professional (flight nurse, flight physician, or flight paramedic) who possesses the knowledge, experience and is legally qualified to provide clinical supervision.

5.1.1.2.1 Credentials/Experience. The clinical care supervisor must possess the following qualifications:

5.1.1.2.1.1 If the clinical care supervisor is a physician, ABEM, or ABOEM certified or currency in CPR, ACLS, and advanced trauma life support (ATLS).

5.1.1.2.1.2 If the clinical care supervisor is a registered nurse, currency in CPR, ACLS, and the Flight Nurse Advanced Trauma Course (FNATC).

5.1.1.2.1.3 If the clinical care supervisor is a paramedic, currency in CPR, ACLS, and PHTLS or International Trauma Life Support (ITLS).

5.1.1.2.1.4 General requirements regardless of provider level:

5.1.1.2.1.4.1 Current specialty education consistent with the mission statement of the air medical ambulance service (e.g., Neonatal Resuscitation Certification Program, Pediatric Advanced Life Support Certification, etc.). Alternatively, the clinical care supervisor must have immediate access to specialty personnel as consultants.

5.1.1.2.1.4.2 In-flight patient care limitations, e.g., assessment and invasive procedures.

5.1.1.2.1.4.3 Infection control.

5.1.1.2.1.4.4 Stress recognition and management.

5.1.1.2.1.4.5 Altitude physiology/stressors of flight.

5.1.1.2.1.4.6 Appropriate utilization of air medical ambulance services.

5.1.1.2.1.4.7 Access to the Delaware Emergency Medical Services EPCR data management system.

5.1.1.2.1.4.8 Hazardous materials scene recognition and response (helicopter services).

5.1.1.2.2 General Areas of Responsibility

5.1.1.2.2.1 Active involvement in the flight program’s QA/ CQI process.

5.1.1.2.2.2 Active involvement in all administrative decisions affecting patient care for the service.

5.1.1.2.2.3 Active involvement in hiring, training, and continuing education of all non-physician air medical personnel for the service.

5.1.1.2.2.4 Active involvement in the care of the critically ill or injured patients.

5.1.1.2.2.5 Ensuring adequate mechanisms are in place for evaluating the clinical practice of the patient care providers.

5.1.2 Direct Care Providers

5.1.2.1 General

5.1.2.1.1 The type of medical care providers staffing each mission shall be directly related to the mission type: advanced life support, specialty care, or basic life support.

5.1.2.1.2 All medical care providers must have current appropriate state licensure or certification which legally allows them to work in their respective professions.

5.1.2.1.2.1 Delaware based programs and out-of-state air medical ambulance programs providing prehospital 911 service must be staffed with Delaware licensed registered nurses and Delaware-certified paramedics.

5.1.2.1.2.2 Out-of-state air medical ambulance programs providing point to point services must be staffed with Delaware licensed registered nurses. Paramedics must be Delaware certified .

5.1.2.1.2.3 Out-of-state air medical ambulance programs providing one way or mutual aid services must be staffed with providers licensed or certified to practice by their state of origin.

5.1.2.1.3 Initial and continuing education requirements for all levels of medical care providers are specified in Appendix A of this regulation.

5.1.2.1.4 Interhospital/Interfacility Transports

5.1.2.1.4.1 A minimum of 2 air medical team members are required to staff interhospital/interfacility ALS/critical care missions. One of the air medical ALS providers must be a member of the regular ALS staff of the air medical ambulance service.

5.1.2.1.4.2 All air medical team members must be licensed, certified, or permitted according to the appropriate state regulations with current re-licensing, recertification, or re-permitting status.

5.1.2.1.4.3 A qualified flight physician or flight registered nurse must be designated as the primary care provider during interfacility or interhospital transports.

5.1.2.1.4.4 A flight paramedic or an approved flight specialty care provider may serve as the second ALS air medical team during an interfacility or interhospital ALS/critical care mission.

5.1.2.1.4.4.1 The specialty care provider must have expertise relative to the needs of the patient.

5.1.2.1.4.4.2 Point to point interfacility transfers within Delaware must utilize the Delaware receiving facility for online medical control.

5.1.2.1.4.4.3 In lieu of compliance with subsection 5.1.2.1.4.4.2 of this regulation, all physicians providing centralized medical control must be Delaware licensed, and a status update must be provided to the receiving facility prior to arrival of the patient.

5.1.2.1.4.4.4 The paramedic on interhospital/interfacility transports must be certified and work according to their standard treatment protocols.

5.1.2.1.4.5 One ALS air medical care provider may be considered sufficient staff for ALS missions, where the patient has been categorized and documented as being stable, by the sending physician, and requires limited ALS care.

5.1.2.1.4.5.1 For the purpose of subsection 5.1.2.1.4.5 of this regulation, "limited ALS care" means patient assessment, monitoring, and interventions common to, and within the scope of practice of the paramedic. Patients may require cardiac monitoring or intravenous therapy (without medication additives).

5.1.2.1.4.5.2 A flight paramedic or registered nurse may serve as the single care provider for the transport of stable ALS patients who meet the criteria as established by the operation or agency medical director.

5.1.2.1.5 Prehospital Scene Responses

5.1.2.1.5.1 Except as provided below, the Delaware State Police (DSP) Paramedic Service is the primary air medical ambulance service authorized to engage in prehospital scene responses and transports in the State of Delaware.

5.1.2.1.5.2 A flight paramedic must be a crew member on all prehospital missions. The aeromedical crew assumes patient care responsibility while the patient is secured on the aircraft.

5.1.2.1.5.3 Non-scheduled aeromedical personnel may be added as the second medical team member according to the protocols of the air medical ambulance services as long as an orientation has been conducted which includes in-flight treatment protocols, general aircraft safety, emergency procedures, operational policies, and infection control.

5.1.2.1.5.4 Air medical ambulance services, other than DSP, may engage in prehospital scene responses and transports in accordance with a service agreement with the Division and DSP to perform prehospital scene responses and transports. The air medical ambulance service must have previously entered into a service agreement with the Division and the Delaware State Police.

5.1.2.1.5.5 All requests for air medical ambulance services, other than the DSP, must be initiated by the emergency communications center responsible for managing or coordinating emergency medical services resources in the county where the need for assistance exists.

5.1.2.1.5.6 All patient care services provided by the air medical service ambulance crew during a prehospital scene response shall be documented using the current State of Delaware approved Electronic Patient Care Report (EPCR). Data provided will be used for descriptive and quality management purposes, including air service utilization review.

5.1.2.1.5.6.1 This data shall be provided in addition to any documentation that the air medical ambulance service generates internally.

5.1.2.1.5.6.2 The EPCR system is the secure Internet-based data management system used for prehospital scene response documentation. Access to an Internet connection is necessary to provide the documentation required by this regulation.

5.1.2.2 Advanced Life Support (ALS) Mission Providers. An advanced life support (ALS) mission is commensurate with the scope of practice of a flight physician, flight nurse, or flight paramedic.

5.1.2.3 Specialty Care Mission Providers

5.1.2.3.1 A specialty care mission is defined as the transport of a patient requiring special patient care by 1 or more professionals who must be added to the regularly scheduled air medical ambulance service team. Dedicated teams providing specialty-oriented care (e.g., neonatal, critical care, extra corporeal membrane oxygenation (ECMO), and pediatric transport teams) must follow the specific mission standards.

5.1.2.3.2 The air medical team must minimally consist of a specially trained physician or registered nurse as the primary caregiver whose expertise must be consistent with the needs of the patient.

5.1.2.3.3 Specialty care missions require at least 2 air medical team members while a patient is, or patients are onboard. Personnel shall be available for each transport within a reasonable time determined by the service.

5.1.2.3.4 All specialty team members must have received a basic minimum orientation to the air medical ambulance service which includes in-flight treatment protocols, general aircraft safety and emergency procedures, operational policies, and infection control.

5.1.2.3.5 Specialty care mission personnel must be accompanied by at least 1 regularly scheduled air medical staff member of the air medical ambulance service, except when independent, dedicated flight specialty teams are used.

5.1.2.3.6 Specialty care personnel must be educated in in-flight treatment modalities, altitude physiology, general aircraft safety, and emergency procedures.

5.1.2.4 Basic Life Support Mission Providers. A basic life support (BLS) mission is generally defined as the transport of a patient who receives care during an interfacility/interhospital transport that is commensurate with the scope of practice of an emergency medical technician-basic (EMT-B). In the State of Delaware, when basic life support care is provided in the air medical ambulance environment, the care must be provided, at a minimum, by a flight emergency medical technician-paramedic (EMT-P).

5.2 Pilot Personnel

5.2.1 There shall be enough pilots permanently assigned to the air medical ambulance service to provide services approved by the Division of Public Health, and which assures adequate crew rest as per FAA regulations.

5.2.2 All pilots must possess a commercial rotorcraft-helicopter airman’s certificate.

5.2.3 The pilot in command (PIC) must possess 2,000 rotorcraft flight hours as PIC prior to assignment with an air medical ambulance service or be currently employed by the Delaware State Police (DSP) and have completed a DSP pilot training program.

5.2.4 A planned structure program must be provided for relief pilots, which at a minimum, includes specific roles and responsibilities, and familiarization with the region served.

5.2.5 A lead pilot and designated safety officer must be appointed by the FAR 135 certificate holder to ensure adherence to operational safety regulations for the program. Adequate training and experience in air medical mission management and evaluation skills must be possessed to carry out these duties.

5.2.6 The pilot has the right to decline or abort any portion of a mission if there is doubt as to the safety of the mission.

5.2.7 The pilot shall meet education and experience requirements as listed in Appendix A of this regulation. Pilots employed by DSP must comply with the requirements set by that agency.

5.3 General Staff Policies - Operational policies must be present to address the following areas:

5.3.1 Medical Flight Personnel

5.3.1.1 Minimize duty-related fatigue;

5.3.1.2 Hearing protection;

5.3.1.3 Crash survivabiity:

5.3.1.3.1 Flame retardant clothing;

5.3.1.3.2 Seat belts/shoulder harnesses;
5.3.1.3.3 Head-strike protection;
5.3.1.3.4 Securement of on-board and carry-on medical equipment.
5.3.1.4 Protective clothing and dress codes relative to:
5.3.1.4.1 Mission type; and
5.3.1.4.2 Infection control.
5.3.1.5 Universal infection control;
5.3.1.6 Flight status during pregnancy;
5.3.1.7 Flight status during acute illnesses (especially respiratory ailments);
5.3.1.8 Flight status while taking medications that may cause dizziness;
5.3.1.9 Weight/height or lifting abilities, if appropriate.
5.3.2 Pilot Personnel
5.3.2.1 Minimize duty-related fatigue; and
5.3.2.2 A policy of the certificate holder that specifies higher weather minimums for new pilots for a time frame based on the pilot's experience, flight time, local environment, and personal adaptation. An evaluation tool applied individually to each new pilot by the flight program shall define the time frame.

4 DE Reg. 1827 (5/1/01)
5 DE Reg. 1727 (3/1/02)
29 DE Reg. 411 (11/01/25)

6.0 Aircraft Requirements

6.1 Medical Considerations
6.1.1 The aircraft shall have an interior medical configuration that is installed according to FAA criteria. Minimum specifications are listed in Appendix B of this regulation.
6.1.2 The aircraft must be configured in such a way that the air medical personnel have access to the patient for the initiation or maintenance of basic advanced life support treatments.
6.1.3 The aircraft must be equipped with medical equipment and supplies consistent with the mission statement and scope of care. Minimum equipment and supplies required are identified in Appendix B of this regulation.
6.1.4 The aircraft design and configuration must not compromise patient stability during loading, unloading, or in-flight operations.
6.1.4.1 The aircraft must have an entry that allows loading and unloading without excessive movement of the patient or compromise to monitoring systems, without interfering with the pilot's vision. The cockpit should be capable of being shielded from light in the patient care area during night operations.
6.1.4.2 The cockpit must be sufficiently isolated, by protective barrier, to minimize distractions from the patient care compartment.
6.1.4.3 The interior of the aircraft must be climate controlled to prevent adverse effects upon the patient from temperature extremes.
6.1.4.4 The avionics shall not interfere with the functioning of medical equipment, intravenous lines, or manual or mechanical ventilation.
6.1.4.5 Adequate interior lighting shall be available to allow for patient care monitoring. Medical equipment shall not interfere with the avionics of the aircraft.
6.2 Aircraft Equipment
6.2.1 The aircraft must be equipped with a 180-degree controllable searchlight of at least 400,000 candle power for rotor-wing aircraft.
6.2.2 Radio capabilities
6.2.2.1 Radios (as range permits) shall be capable of transmitting and receiving communications from:
6.2.2.1.1 Medical control;
6.2.2.1.2 Flight operations center;
6.2.2.1.3 Air traffic control; and
6.2.2.1.4 EMS and law enforcement agencies.
6.2.2.2 The pilot must be able to control and override radio transmissions from the cockpit in the event of an emergency.
6.2.2.3 The flight crew must be able to communicate within the aircraft and with FAA personnel.
6.2.3 The aircraft must be equipped with a functioning emergency locator transmitter (ELT) in compliance with the applicable Federal Aviation Regulations (FARs).

6.2.4 A fire extinguisher must be accessible to air medical personnel and pilots in compliance with applicable FARs.

6.3 Maintenance. Maintenance may be provided by an outside vendor who is FAA and manufacturer certified. If an in-house maintenance department is utilized, the following criteria must be met:

6.3.1 Credentials/Experience

6.3.1.1 The lead mechanic must possess 2 years of rotorcraft experience as a certified airframe and power plant mechanic prior to assignment with an air medical ambulance service.

6.3.1.2 The mechanic must be factory schooled or equivalent in an approved program, and FAR 135 qualified to maintain the aircraft designated by the air medical ambulance service.

6.3.2 Training Related to the Interior Modification of the Aircraft:

6.3.2.1 Shall educate the mechanic in the inspection of the installation as well as the removal and reinstallation of special medical equipment.

6.3.2.2 Supplemental training on service and maintenance of medical oxygen systems, and a policy as to who maintains responsibility for refilling the medical oxygen system.

6.3.3 Staffing of Mechanics

6.3.3.1 A single mechanic on duty or on call 24 hours a day shall be relieved from duty for a period of at least 24 hours during any 7 consecutive days, or the equivalent thereof, within any 1 calendar month.

6.3.3.2 Back-up personnel shall be provided to the mechanic during periods of extensive scheduled or unscheduled maintenance or inspection. Complexity of the aircraft and an increased number of flight hours may be considerations for increased mechanic staffing.

6.3.3.3 A policy of the certificate holder shall be in place that documents the disciplinary process for a mechanic.

6.3.4 Maintenance Facilities

6.3.4.1 There must be a mechanism/procedure for alerting flight and air medical ambulance personnel when the aircraft is not air worthy.

6.3.4.2 A hangar or similar-type facility shall be available for the mechanic to perform heavy maintenance.

4 DE Reg. 1827 (5/1/01)
29 DE Reg. 411 (11/01/25)

7.0 Visual Flight Rules (VFR) for Weather Issues

7.1 VFR for weather minimums shall be specified for day and night local, and day and night cross country (CC).

7.2 The "local flying area" shall be determined by the operator based upon the operating environment.

7.3 There is a system of obtaining pertinent weather information.

7.3.1 The pilot in command (PIC) is responsible for obtaining weather information according to policy, which shall address, at a minimum:

7.3.1.1 Routine weather checks;

7.3.1.2 Weather checks during marginal conditions; and

7.3.1.3 Weather trending.

7.3.2 Communication between pilots, medical personnel, and communication specialists at shift change regarding the most current and forecasted weather shall be included in a formal briefing.

7.4 VFR "response" weather minimums.

Recommended minimums to begin a transport shall be no less than:

CONDITIONS	CEILING	VISIBILITY
DAY/LOCAL	800 ft.	2 miles
DAY/CC	800 ft.	3 miles
NIGHT/LOCAL	800 ft.	3 miles
NIGHT/CC	1,000 ft.	3 miles

7.5 Policies shall include provisions for patient care and transport alternatives if the aircraft must use alternate landing facilities due to deteriorating weather.

7.6 Instrument meteorological conditions (IMC)) - Weather Issues. When transitioning to an off-airport site after an instrument approach, the following shall apply:

7.6.1 Local VFR weather minimums shall be followed if within a defined local area and if the route and off-airport site are familiar.

7.6.2 Cross-country VFR weather minimums shall be followed if not in defined local area or if not familiar with route and off-airport site.

4 DE Reg. 1827 (5/1/01)
29 DE Reg. 411 (11/01/25)

8.0 Helipad

8.1 Primary, receiving hospital helipads must be marked (with a painted "H" or similar landing designation), lighted for night operations, and be equipped with a device to identify wind direction. In addition, there shall be:

8.1.1 Unobstructed approach according to the FAA Advisory circular entitled Heliport Design Advisory Circular, AC 150/5390-2.

8.1.2 Evidence of compliance with local, state, or federal regulations including appropriate and fire-retardant chemicals.

8.1.3 Documented ongoing safety programs for those responsible for loading and unloading patients or working around the helicopter on the helipad.

8.1.4 Evidence of adequate security, with a minimum of 1 person to prevent bystanders from approaching the helicopter as it lands or lifts off, or perimeter security such as fencing, rooftop etc. A means must exist to monitor the primary helipad if accessible to the public (e.g., through direct visual monitoring or closed-circuit TV).

8.1.5 There is limited distance from the helipad, (a limited distance means not requiring intermediary transport of any type from the helipad to the receiving facility), to the hospital to minimize the effects to the patient.

8.1.5.1 Patient monitoring shall continue without interruption between the helipad and the hospital.

8.1.5.2 Emergent patient interventions can be performed as needed between helipad and hosptial and hearing protection is provided for all personnel who assist with patient hot loading and unloading.

8.1.6 Hearing protection is provided for and shall be worn by all personnel who assist with patient hot loading and unloading.

8.2 Occasional or episodic use of helipads. Helipads used occasionally (at referring or receiving hospitals) shall be reviewed annually by the air medical ambulance service for:

8.2.1 Identification and removal of obstructions;

8.2.2 Appropriate lighting (permanent or temporary for night operations);

8.2.3 Helicopter ingress/egress limitations;

8.2.4 Adequate security - a minimum of 1 person to prevent bystanders from approaching the helicopter as it lands or lifts off; and

8.2.5 Evidence of safety programs (through review of training program records) offered to personnel responsible for operations at the landing site and availability of appropriate fire-retardant chemicals.

8.3 Temporary scene landings shall be secured, with:

8.3.1 Perimeter lighting with handheld floodlights, emergency vehicles, or other lighting source to clearly illuminate the designated landing area at night.

8.3.2 No overhead obstruction or ground debris.

8.3.3 The scene landing appropriate in size to the type of the aircraft.

8.3.4 Safety programs provided to public safety/law enforcement agencies that include:

8.3.4.1 Identifying and designating an appropriate landing zone (LZ); and

8.3.4.2 Helicopter safety.

8.3.5 Two-way communications between helicopter and ground personnel.

4 DE Reg. 1827 (5/1/01)
29 DE Reg. 411 (11/01/25)

9.0 Communications

9.1 The flight crew or a communication specialist must assume the responsibility of receiving and coordinating all requests for the air medical ambulance service.

9.1.1 Should a communication specialist be employed, training shall be commensurate with the scope of responsibility of the communications center personnel and include:

9.1.1.1 EMT-B certification or equivalent knowledge and experience.

9.1.1.2 Knowledge of Federal Aviation Administration Regulations and Federal Communications Commission Regulations pertinent to the air medical ambulance service.
9.1.1.3 General safety rules and emergency procedures pertinent to air medical ambulance transportation and flight following procedures.
9.1.1.4 Navigation techniques/terminology and understanding weather interpretation.
9.1.1.5 Types of radio frequency bands used in air medical ambulance EMS.
9.1.1.6 Assistance with the materials response and recognition procedure using appropriate reference materials.

9.2 Communication policies of the air medical ambulance service must reflect:
9.2.1 Aircraft communication, when possible, with ground units, securing unprepared landing sites prior to landing.
9.2.2 A readily-accessible post incident/accident plan, which must be part of the flight following protocol, so that appropriate search and rescue efforts may be initiated in the event the aircraft is overdue, radio communication cannot be established, nor location verified. The plan shall include the following:
9.2.2.1 Written post incident/accident plans that are easily identified and readily available.
9.2.2.2 Current phone numbers that are easily accessible.
9.2.2.3 An annual drill conducted to exercise the post incident/accident plan.

9.3 Continuous flight following must be monitored, documented, and shall consist of the following:
9.3.1 Initial coordination to include communication and documentation of:
9.3.1.1 Time call received;
9.3.1.2 Name and phone number of requesting agency;
9.3.1.3 Time aircraft departed;
9.3.1.4 Pertinent LZ information;
9.3.1.5 Number of persons on board;
9.3.1.6 Amount of fuel on board;
9.3.1.7 Estimated time of arrival (ETA);
9.3.1.8 Diagnosis or mechanism of injury;
9.3.1.9 Referring and receiving facilities (for interfacility transports) as per policy of the air medical ambulance service; and
9.3.1.10 Verification of acceptance of patient.
9.3.2 Communications during mission shall also be documented accordingly:
9.3.2.1 Direct or relayed communications to the communications center (while in flight), specifying locations, ETAs, and deviations, if necessary;
9.3.2.2 Direct or relayed communications to communications center specifying all take-off and landing information; and
9.3.2.3 Time between each communication:
9.3.2.3.1 Time between each communication shall not exceed 15 minutes while in flight. If an IFR or VFR flight plan has been filed, the pilot or pilots may only be able to communicate with air traffic control (ATC) when real-time tracking is not online.
9.3.2.3.2 Time between communications shall not exceed 45 minutes while on the ground.
9.3.2.3.3 Alternate agencies are used to relay communications when direct contact is not possible.

9.4 The Communications Center must contain the following:
9.4.1 At least 1 dedicated phone line for the air medical ambulance service.
9.4.2 A system for recording all incoming and outgoing telephone and radio transmissions with time recording and playback capabilities. Recordings are to be kept for 30 days.
9.4.3 Capability to immediately notify the air medical ambulance team and online medical direction (through radio, pager, telephone, etc.).
9.4.4 Back-up emergency power source for communications equipment, or a policy delineating methods for maintaining communications during power outages and in disaster situations.
9.4.5 A communications policy and procedures manual.

9.5 All air medical ambulance services that will be landing at a healthcare facility helipad within the state must contact DSP Aviation Communications (AVCOM) at 302-739-5964 to advise the healthcare facility of the air medical ambulance service's destination and the estimated length of time that the service will occupy the helipad. AVCOM must be advised again when the aircraft departs the helipad.

4 DE Reg. 1827 (5/1/01)
5 DE Reg. 1727 (3/1/02)
29 DE Reg. 411 (11/01/25)

10.0 EMS System Integration

10.1 The air medical ambulance service shall be integrated with and communicate with other public safety agencies, including ground emergency service providers. Communication must include participation in regional quality assurance reviews, regional disaster planning, and mass casualty incident drills.

10.2 The air medical ambulance service must interface (through telephone calls and outreach programs) with existing communications centers, public safety, and law enforcement agencies, as well as with local off-line medical directors, as appropriate for prehospital ALS missions.

10.3 The air medical ambulance service must ensure continuity of care and expeditious treatment of patients by utilizing state EMS medical protocols and procedures, whenever applicable.

10.4 All 911 missions must utilize the Delaware paramedic standing orders and (in-state) Delaware certified medical control physicians for online medical control.

10.5 The air medical ambulance service shall facilitate integration of all emergency services and transport modalities by supporting joint continuing education programs and operational procedures for:

10.5.1 Disaster response/triage;

10.5.2 Interface of the air medical ambulance team with other regional resources;

10.5.3 Safety program consisting of patient preparation and personal safety around the aircraft to include landing zone (LZ) designation for rotary wing services; and

10.5.4 Patients considered appropriate for transport by the air medical ambulance service.

10.6 The service shall promote timely feedback to the referring agency, facility, or physician about patient outcome and treatment rendered before, during, and after transport, when appropriate.

10.7 The flight service shall provide a planned, structured safety program to public safety/law enforcement agencies and hospital personnel who interface with the air medical ambulance service, which includes:

10.7.1 Landing zone designation and preparation;

10.7.2 Personal safety in and around the helicopter for all ground personnel;

10.7.3 Procedures for day/night operations, conducted by the air medical ambulance team, specific to the aircraft, which shall include:

10.7.3.1 High and low reconnaissance;

10.7.3.2 Communication and coordination with ground personnel;

10.7.3.3 Approach and departure path selection;

10.7.3.4 Procedures for the pilot to ensure safety during ground operations in the landing zone with or without engines running; and

10.7.3.5 Procedures for the pilot to have ground control during engine start and departure from a landing site.

10.8 The air medical ambulance service shall maintain records of initial and recurrent training provided by the air medical ambulance service to prehospital referring and receiving ground support personnel.

4 DE Reg. 1827 (5/1/01)
5 DE Reg. 1727 (3/1/02)
29 DE Reg. 411 (11/01/25)

11.0 Post Incident/accident Plan

11.1 A Post Incident/accident Plan shall be written and understood by all program personnel, and shall include at a minimum:

11.1.1 A list of personnel to notify in order of priority (for a communication specialist to activate) in the event of a program incident/accident. Two major goals in activating a notification list include:

11.1.1.1 Providing rapid rescue response; and

11.1.1.2 Ensuring accurate information dissemination.

11.1.2 A preplanned time frame to activate the Post Incident/accident Plan for overdue aircraft.

11.1.3 Procedures to secure all documents, audio, and video recordings related to the incident/accident.

11.1.4 Procedures for releasing information to the press.

4 DE Reg. 1827 (5/1/01)
29 DE Reg. 411 (11/01/25)

12.0 Professional and Community Education

12.1 A professional and community education program or printed information with the target audience to be defined by the air medical ambulance service shall include:

12.1.1 Hours of operation, phone number, and procedure to access;

12.1.2 Capabilities of air medical ambulance personnel;

12.1.3 The type of aircraft and type-specific operational protocols;

12.1.4 The service area for the aircraft;
12.1.5 Preparation and stabilization of the patient;
12.1.6 A safety program consisting of protocols for patient preparation and personal safety around the aircraft to include landing zone (LZ) designation for rotor wing services; and
12.1.7 Patients considered appropriate for transport by the air medical ambulance service. (An appropriate transport typically enhances patient outcome, safety, or cost effectiveness over other modes of transport).

29 DE Reg. 411 (11/01/25)

13.0 Infection Control

13.1 Policies and procedures addressing patient transport issues involving communicable diseases, infectious processes, and health precautions for emergency personnel as well as for patients must be current with the local standard of practice, standards of the Occupational Safety and Health Administration (OSHA), and as published by the Centers for Disease Control and Prevention (CDC).
13.2 Policies and procedures must be in place and readily available to all personnel of the air medical ambulance service.
13.3 Additional medical and agency resources pertinent to infection control must be identified and made available in the policy manual to all air medical ambulance service personnel.
13.4 Education programs shall include the institution's/air medical ambulance service's infection control resources, programs, policies, and CDC recommendations. Policies and procedures shall be reviewed on an annual basis.
13.5 Air medical personnel transporting patients must practice preventative measures lessening the likelihood of transmission of pathogens. Policies and procedures shall address:
13.5.1 Personnel health concerns, including record of:
13.5.1.1 Physical exams;
13.5.1.2 Immunization history – air medical ambulance service personnel are encouraged to have tetanus and hepatitis B immunization.
13.5.1.3 Verification of post-vaccination antibody status, if immunized against hepatitis B; and
13.5.1.4 Measles, mumps, and rubella (MMR) immunization.
13.5.2 Management of communicable diseases and infection control in the transport environment shall be outlined as follows:
13.5.2.1 The use of gloves, eye protection, and face masks;
13.5.2.2 The use of a sharps disposal container for contaminated needles and a collection container for soiled disposable items on the aircraft;
13.5.2.3 Protocols for cleaning and disinfecting with appropriate disinfectant of the patient cabin area, equipment, and personnel's soiled uniforms;
13.5.2.4 Mechanisms for identifying those at risk for exposure to an infectious disease;
13.5.2.5 A plan for communication between the air medical ambulance service personnel, EMS providers, and the hospital when exposure is suspected/confirmed to include the following:
13.5.2.5.1 The prompt release of written notification in accordance with OEMS infection control guidelines; and
13.5.2.5.2 Follow-up documentation.
13.5.2.6 A policy for special provisions for transporting infected or possibly infected patients;
13.5.2.7 Proper cleaning or sterilization of all appropriate instruments or equipment; and
13.5.2.8 Hand washing before and after transporting each patient.

29 DE Reg. 411 (11/01/25)

14.0 Quality Assurance/continuous Quality Improvement

14.1 The agency must establish a Quality Assurance/Continuous Quality Improvement (QA/CQI) Program which provides ongoing monitoring and evaluation of the quality and effectiveness of the air medical ambulance service.
14.2 The QA/CQI Program shall be comprehensively integrated, and include activities related to patient care, communications, aviation, operations, and equipment maintenance. The required elements and considerations of the written QA/CQI Plan are listed in Appendix C of this regulation.
14.3 The medical director has the primary responsibility of ensuring timely review of patient care activities and issues, the patient's medical record, and pre-established QA/CQI criteria. A committee consisting of the medical director along with representatives of the air medical ambulance service's management, medical, and non-medical personnel should be considered as a mechanism for ensuring initiation and continuation of the QA/CQI Program.

14.4 The air medical ambulance service shall provide a policy and procedure manual which shall be reviewed at least annually for accuracy, completeness, and currency for all air medical ambulance service personnel.

14.5 The air medical ambulance service shall establish and implement patient care guidelines/standing orders which must be reviewed annually (for content accuracy) by the air medical ambulance service management, QA/CQI committee members, and the medical director.

14.6 The QA/CQI Program must be closely integrated with risk management, to facilitate follow-up of concerns identified through the Quality Improvement Program.

29 DE Reg. 411 (11/01/25)

15.0 General Policies

15.1 All air medical ambulance service providers operating in Delaware shall establish and implement the following policies:

15.1.1 Well-defined lines of authority with procedures for clear reporting to upper-level agency management;

15.1.2 Understanding the organizational structure and the chain of command;

15.1.3 The air medical ambulance service's disciplinary process for all levels of staff;

15.1.4 Encouraging ongoing communications between all air medical ambulance service personnel;

15.1.5 Protocol for formal, periodic staff meetings for which minutes are kept on file. These guidelines shall include methods for disseminating information between meetings;

15.1.6 Identifying lines of authority between the air medical ambulance service management team, the aviation management team, and public or private institutions and agencies that contract with an aviation firm to provide air medical ambulance services; and

15.1.7 Guidelines for press-related issues and marketing activities.

15.1.8 Policies Relating to Patient Management

15.1.8.1 All transfers of patient care shall occur from a lower level of care to an equal or higher level of care, except for elective transfers for patient convenience or returning a patient to a referring facility.

15.1.8.2 A patient record shall be maintained on all patients utilizing the services of an air medical ambulance. The record shall be used to document care given during transport, as well as all other relevant patient related factors, including status prior to, during, and at the end of transport. The current Delaware-approved EPCR shall be utilized to document all patient contacts.

15.1.8.3 The air medical ambulance services will utilize Delaware Standing Orders and online medical direction for patient care treatment.

15.1.8.4 Interfacility transports require physician referral/acceptance to ensure continuity of care and establish patient care parameters during the transport. Patient transfer protocols must comply with existing federal requirements.

15.1.8.5 Management ensures an appropriate utilization review process based on the following medical benefits to the patient:

15.1.8.5.1 Timeliness of the transport as it relates to the patient's clinical status;

15.1.8.5.2 Transport to an appropriate receiving facility, which may include:

15.1.8.5.2.1 A hospital or facility where the patient has previously undergone specialized treatment and where the patient's previous medical records are located;

15.1.8.5.2.2 A facility at too great a distance for ground transport; or

15.1.8.5.2.3 A facility with a specialized level of care not available in the referring hospital.

15.1.8.5.3 Specialized air medical personnel expertise available during transport that would otherwise not be available; and

15.1.8.5.4 Safety of the transport environment.

15.1.9 Cost of the Transport

15.1.9.1 A structured, periodic review of flights (to determine transport appropriateness or that the mode of transport enhances medical outcome, safety, or cost effectiveness over other modes of transport) performed at least semi-annually and resulting in a written report.

15.1.9.2 The hospital or non-hospital-based program director/administrator is ensuring compliance with the specific sections of the FAR that are pertinent to the air medical ambulance service.

15.1.10 Policies Pertaining to Safety

15.1.10.1 A Safety Committee shall meet at least quarterly and prepare written reports to be sent to management and kept on file as dictated by policy. The responsibilities of the Safety Committee may be assumed by the QA/CQI Committee.

15.1.10.2 Written variance requests relating to safety issues will be addressed in Safety Committee meetings. The Safety Committee will promote communications between air medical ambulance personnel and pilots addressing safety, practice, concerns, issues, and questions.

15.1.10.3 Safety Committee recommendations for operational and safety issues will be reviewed by management.

4 DE Reg. 1827 (5/1/01)
29 DE Reg. 411 (11/01/25)

APPENDIX A
Educational Requirements
https://regulations.delaware.gov/AdminCode/title16/4302/4016fdc9-b616-467a-968b-14601114f3dc
29 DE Reg. 411 (11/01/25)

APPENDIX B
Aircraft and Equipment
https://regulations.delaware.gov/AdminCode/title16/4302/04a5a110-2d71-4143-a844-ffe5d6f380f9
29 DE Reg. 411 (11/01/25)

APPENDIX C
Quality Management
https://regulations.delaware.gov/AdminCode/title16/4302/aa585af3-6966-4178-aeca-9e315a2e2d9a
29 DE Reg. 411 (11/01/25)

---

4 DE Reg. 1827 (5/1/01)
5 DE Reg. 1727 (3/1/02)
29 DE Reg. 411 (11/01/25)