

# IVA-riktlinjer ur ett europeiskt perspektiv – fokus på organisationsfrågor

# Riktlinjer Svensk intensivvård

## 2.1 Intensivvård kategori III

Allmänna intensivvårdsavdelningar på exempelvis region-/universitetssjukhus tillhandahåller de mest kvalificerade övervaknings- och behandlingsmetoder som kan erbjudas vid olika typer av organsvikt. Dessa avdelningar uppfyller samtliga krav på organisation, kompetens och kringresurser enligt rekommendationen för kategori III (se 6.1).

På region-/universitetssjukhus finns dessutom ofta specialintensivvårdsavdelningar för t ex thorax- och neurokirurgi, pediatrik och brännskadevård. Även sjukhus med intensivvård kategori II-III är beroende av dessa avdelningar för remittering av patienter. Avsändande sjukhus ska kunna förvänta sig att dessa patienter erbjuds högre intensivvårdskompetens än på hemsjukhuset. Organisatoriskt ligger specialintensivvårdsavdelningar sällan under samma verksamhetsområde som allmänna intensivvårdsavdelningar. Sådana specialiserade avdelningar behöver uppfylla kraven för kategori III, då de annars hamnar på en lägre vårdnivå.

## 2.2 Intensivvård kategori II

Intensivvårdsavdelningar på exempelvis länssjukhus behärskar intensivvård vid akut funktionsnedsättning i de flesta organsystem, framförallt cirkulations- och respirationssvikt, men saknar de allra mest kvalificerade metoder för övervakning/ behandling av svikt i ett eller flera organsystem, som kan erbjudas på avdelning kategori III. Dessa avdelningar uppfyller samtliga krav på organisation, kompetens och kringresurser enligt rekommendationerna för kategori II (se 6.1) och har en fungerande organisation för säker transport av patienter till och från intensivvård kategori III.

# Riktlinjer Svensk intensivvård

## 2.3 Intensivvård kategori I

Intensivvårdsavdelningar på exempelvis länsdelssjukhus behärskar intensivvård vid akut funktionsnedsättning i flera organsystem, men saknar möjlighet att erbjuda intensivvård på samma nivå som kategori II- och III-avdelningar. Dessa avdelningar uppfyller samtliga krav på organisation, kompetens och kringresurser enligt rekommendationerna för kategori I (se 6.1) och har en fungerande organisation för säker transport av patienter till och från intensivvård kategori II-III.

## 2.4 Intermediärvård

Intermediärvård kan erbjudas då medicinsk indikation för intensivvård inte föreligger, men då patientens medicinska/omvårdnadsmissiga behov inte kan tillgodoses på vårdavdelning.

Intermediärvård kan organisatoriskt bedrivas av intensivvården, men också av andra verksamheter och specialiteter. Om indikation för högre vårdnivå föreligger ska patienten överföras till intensivvårdsavdelning. Intermediärvård bedrivs lämpligen, liksom intensivvård, i multidisciplinärt samarbete mellan representanter för inblandade specialiteter. Intermediärvårdsarbetet ska, liksom intensivvården, präglas av ett etiskt förhållningssätt (se 4.4). Lokala riktlinjer ska finnas för organisation, personaltäthet och – kompetens, samt för vilka medicinska indikationer intermediärvård ska erbjudas. Säkerhetsaspekter avseende behandlingar som normalt hör hemma på intensivvårdsavdelning skall speciellt beaktas och utvärderas. Eftersom intensivvård i Sverige är, även i internationell jämförelse, begränsad resurs finns risk för indikationsglidning avseende intermediärvård. Sådan glidning behöver aktivt motverkas.

# Riktlinjer Svensk intensivvård

## 6.1.1.1. Kompetenskrav och ledningsfunktioner, ledningsansvarig läkare

	Kategori I	Kategori II	Kategori III
Specialistkompetens i anestesi och intensivvård	+	+	+
Fördjupningsutbildning i intensivvård inkl EDIC	(+)	+	+
Medicinskt ledningsansvar	+	+	+
Ekonomiskt ansvar	(+)	(+)	+
Omvårdnadsansvar	+	+	+
Utbildningsansvar	+	+	+
Andel av tjänst inom intensivvård	≥50%	≥50%	≥90%

## 6.1.2. Bemanningskrav, kontorstid

Ledningsansvarig läkare	+	+	+
Läkare med specialistkompetens i anestesi och intensivvård (antal per vårdplats)	1/avd	0,15-0,5	0,25-0,5
Läkare under utbildning (ST eller AT)	(+)	+	+
Ledningsansvarig sjuksköterska	+	+	+
sjuksköterska, vidareutbildad i intensivvård	(+)	+	+
Annan vårdpersonal under utbildning	(+)	+	+
Kliniskt verksam vårdpersonal inkl läkare (antal per patient)	0,67-1	1-2	1,5-3
fysioterapeut (andel av heltidstjänst)	25-50%	50-100%	100%
Kurator (andel av heltidstjänst)	10-25%	25-50%	50-100%

# Riktlinjer Svensk intensivvård

## 6.1.4. Tillgänglighetskrav, primärjour intensivvård

Dygnet runt	+	+	+
Sjukhusbunden	(+)	+	+

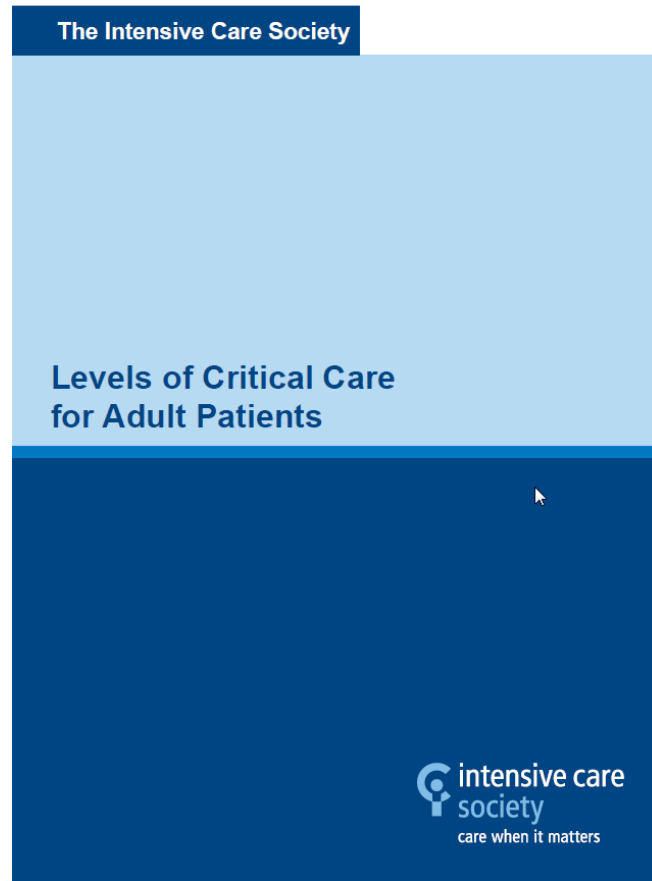
## 6.1.5.1. Kompetenskrav, primärjour intensivvård

Legitimerad läkare	+		
Minst sex månaders klinisk tjänstgöring med goda vitsord inom huvudspecialiteten som ST-läkare i anesthesi och intensivvård	(+)	+	
Specialistkompetens i anesthesi- och intensivvård	(+)	(+)	+

## 6.1.5.2. Kompetenskrav, bakjour

Specialistkompetens i anesthesi- och intensivvård med fortlöpande rotationstjänstgöring enligt 3.2	+	+	+
Specialistkompetens i anesthesi- och intensivvård med fördjupning inom intensivvård enligt 5.1		(+)	(+)

# Levels of Critical Care



- Beskriver vårdnivåer
- Vuxna patienter
- Inga rekommendationer om:
  - Personalkompetens
  - Personaltäthet
  - Lokalutformning
- ”lägre vårdnivå brukar kräva lägre ssk/patient ratio”

# Level 1 Criteria

Level 1 Criteria	Examples
<b>Patients recently discharged from a higher level of care</b>	Patients requiring a minimum of 4 hrly observations.
<b>Patients in need of additional monitoring/clinical interventions, clinical input or advice</b>	<ul style="list-style-type: none"><li>▪ Requiring a minimum of 4 hrly observation on the basis of clinical need.</li><li>▪ Requiring continuous oxygen therapy.</li><li>▪ Boluses of intravenous fluid (need not determined by CVP).</li><li>▪ Epidural analgesia or Patient Controlled Analgesia in use.</li><li>▪ Parenteral nutrition.</li><li>▪ Postoperative surgical patients who are still requiring 4 hrly observations.</li><li>▪ Requiring administration of bolus intravenous drugs through a Central Venous Catheter.</li><li>▪ With a tracheostomy.</li><li>▪ With a chest drain in situ.</li><li>▪ Requiring a minimum of 4 hourly GCS assessment.</li><li>▪ With diabetes receiving a continuous infusion of insulin.</li><li>▪ Who are at risk of aspiration pneumonia.</li><li>▪ On established intermittent renal support.</li><li>▪ Requiring respiratory physiotherapy to treat or prevent respiratory failure.</li><li>▪ Requiring frequent (&gt; 2x day) Peak Expiratory Flow rate measurement for clinical reasons.</li></ul>

# Level 2 Criteria

Level 2 Criteria	Examples
<b>Patients needing pre-operative optimisation</b>	<ul style="list-style-type: none"><li>Cardiovascular, renal or respiratory optimisation required prior to surgery. (Invasive monitoring inserted to assist optimisation (arterial line, and CVP as a minimum)).</li></ul>
<b>Patients needing extended postoperative care</b>	<ul style="list-style-type: none"><li>Immediate care following major elective surgery.</li><li>Emergency surgery in unstable or high risk patients.</li><li>Where there is a risk of postoperative complications or a need for enhanced interventions and monitoring.</li></ul>
<b>Patients stepping down to Level 2 care from Level 3</b>	<ul style="list-style-type: none"><li>Requiring a minimum of hourly observations.</li><li>At risk of deterioration and requiring level 3 care again.</li></ul>
<b>Patients receiving single organ support</b>	
<b><i>(exceptions: Basic Respiratory and Basic Cardiovascular Support occurring simultaneously without any other organ support should be considered as Level 2 and Advanced Respiratory Support alone is Level 3).</i></b>	



# Level 2 Criteria

## Patients receiving Basic Respiratory Support

***(NB: When Basic Respiratory and Basic Cardiovascular support are provided at the same time during the same critical care spell and no other organ support is required, the care is considered to be Level 2 care)***

Indicated by one or more of the following:

- Mask / hood CPAP or mask / hood Bi-level positive airway pressure (non-invasive ventilation)
- Patients who are Intubated to protect the airway but needing no ventilatory support
- CPAP via a tracheostomy
- More than 50% oxygen delivered by face mask. *(Note, more than 50% has been chosen to identify the more seriously ill patients in a hospital).* Short-term increases in FIO<sub>2</sub> to facilitate procedures such as transfers or physiotherapy do not qualify.
- Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support. *(e.g. severely compromised airway or deteriorating respiratory muscle function).*
- Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway
- Patients who are recently (within 24 hours) extubated after a period (greater than 24 hours) of mechanical ventilation via an endotracheal tube.

NB: The presence of a tracheostomy used for long term airway access only does not qualify for basic respiratory support.

# Level 2 Criteria

<p><b>Patients receiving Basic Cardiovascular Support</b></p> <p><i>(NB: When Basic Respiratory and Basic Cardiovascular support are provided at the same time during the same critical care spell and no other organ support is required the care is considered to be Level 2 care)</i></p>	<p>Indicated by one or more of the following:</p> <ul style="list-style-type: none"> <li>Use of a CVP line for monitoring of central venous pressure and /or provision of central venous access to deliver titrated fluids to treat hypovolaemia.</li> <li>Use of an arterial line for monitoring the arterial pressure and/or sampling of arterial blood.</li> <li>Single intravenous vasoactive drug used to support or control arterial pressure, cardiac output or organ perfusion.</li> <li>Single/multiple intravenous rhythm controlling drug(s) to support or control cardiac arrhythmias</li> </ul>	<p><b>Patients receiving Renal Support</b></p> <p>Indicated by:</p> <ul style="list-style-type: none"> <li>Acute renal replacement therapy (e.g. haemodialysis, haemofiltration etc.) or</li> <li>provision of renal replacement therapy to a chronic renal failure patient who is requiring other acute organ support in a critical care bed.</li> </ul>
<p><b>Patients receiving Advanced Cardiovascular Support</b></p> <p><i>(NB: Basic Cardiovascular support will frequently occur prior to Advanced Cardiovascular support and should not lead to both Advanced Cardiovascular support and Basic Cardiovascular support being recorded at the same calendar day. Advanced Cardiovascular support supersedes Basic Cardiovascular support where this occurs.)</i></p>	<p>Indicated by one or more of the following:</p> <ul style="list-style-type: none"> <li>Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ / tissue perfusion, (e.g. inotropes, amiodarone, nitrates). To qualify for advanced support status, at least one drug needs to be vasoactive.</li> <li>Continuous observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal Doppler, impedance and conductance methods).</li> <li>Intra aortic balloon pumping and other assist devices.</li> <li>Insertion of a temporary cardiac pacemaker (criteria valid for each day of therapeutic connection to a</li> </ul>	<p>Indicated by one or more of the following:</p> <ul style="list-style-type: none"> <li>Central nervous system depression sufficient to prejudice the airway and protective reflexes, <u>excluding that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. deliberate or accidental overdose, alcohol, drugs etc.)</u>.</li> <li>Invasive neurological monitoring or treatment e.g. ICP, jugular bulb sampling, external ventricular drain.</li> <li>Continuous intravenous medication to control seizures and / or continuous cerebral monitoring.</li> <li>Therapeutic hypothermia using cooling protocols or devices</li> </ul>

# Level 3 Criteria

Level 3 Criteria	Examples
<p><b>Patients receiving Advanced Respiratory Support alone</b></p> <p><i>(NB: Basic Respiratory support will frequently occur prior to Advanced Respiratory support and should not lead to both Advanced Respiratory support and Basic Respiratory support being recorded at the same calendar day. Advanced Respiratory support supersedes Basic Respiratory support where this occurs.)</i></p>	<p>Indicated by one of the following:</p> <ul style="list-style-type: none"> <li>▪ Invasive mechanical ventilatory support applied via a trans-laryngeal tracheal tube or applied via a tracheostomy.</li> <li>▪ Bi-level positive airway pressure applied via a trans-laryngeal tracheal tube or applied via a tracheostomy</li> <li>▪ CPAP via a trans-laryngeal tracheal tube.</li> <li>▪ Extracorporeal respiratory support.</li> </ul>
<p><b>OR</b></p> <p><b>Patients receiving a minimum of 2 organs supported</b></p> <p><i>(NB: Basic Respiratory and Basic Cardiovascular do not count as 2 organs if they occur simultaneously (see above under Level 2 care), but will count as Level 3 if another organ is supported at the same time)</i></p>	<p>Examples:</p> <ul style="list-style-type: none"> <li>▪ Basic Respiratory and Neurological support.</li> <li>▪ Basic Respiratory and Hepatic Support.</li> <li>▪ Basic Respiratory and Renal support.</li> <li>▪ Basic Cardiovascular and Hepatic support.</li> <li>▪ Basic Cardiovascular and Renal support.</li> <li>▪ Advanced Cardiovascular and Renal support.</li> <li>▪ Advanced Cardiovascular and Hepatic support.</li> <li>▪ Advanced Cardiovascular and Neurological support.</li> </ul>

# Tyskland IVA rekommendationer

4



## Empfehlungen zur Struktur und Ausstattung von Intensivstationen

- Hintergrundtext -

Verabschiedet mit Beschluss des Präsidiums der Deutschen Interdisziplinären Vereinigung für Intensiv- und Notfallmedizin (DIVI) vom 30.11.2010

Erstellt von:

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- Ingen IVA kategorisering.
- Kategorisering av sjukhus med dirigering av patientflöden
  - 3-4 nivåer beroende av delstat

# Tyskland IVA rekommendationer

- Medicinskt ansvarig skall vara intensivist
- 24/7 skall läkare med erfarenhet av intensivvård finnas samt specialist på huset
- 8-12 platser skall ha minst 7 läkartjänster utöver MLA
- 1 ssk/ 2 platser + ansvarig ssk.
  - Vid avancerad plats 1/1 (svensk IVA?)
  - Vidareutbildade ssk > 30 %
- mm.

# Tyskland IVA Kvalitetsindikatorer

- IVA leds av intensivvårdsspecialist
- Kontorstid arbetar 1 IVA specialist
- 1 ssk/ 2 pat
- 24/7 skall läkare och ssk ha intensivvårdserfarenhet

# Andra länder

- Finland
  - Listning av samtliga intensivvårdsavdelningar med storlek
  - Ingen gradering av intensivvårdsavdelningarna
- Schweiz
  - Flerårigt ny uppdaterat(2015) klassificeringssystem
    - Omfattande med personaltäthet, storlek, resurser mm.
    - Ingen gradering av olika typer av Intensivvårdsavdelningar(Ja/Nej)

# Intermediärvårds rekommendationer

## Leitlinien und Empfehlungen

Med Klin Intensivmed Notfmed 2018 · 113:33–44  
<https://doi.org/10.1007/s00063-017-0369-7>  
Published online: 7 November 2017  
© Springer Medizin Verlag GmbH 2017



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## Intermediate care units

## Recommendations on facilities and structure

- German Interdisciplinary Association for Intensive Care and Emergency Medicine(DIVI)
- November 2017
- Ramverk



# Intermediärvårds rekommendationer

## Definition of intermediate care unit

The IMC is suited to the monitoring and treatment of patients with moderate or potentially severe instability of physiological parameters that require equipment-based monitoring and organ support, but do not require organ replacement. This includes patients that require less than normal intensive care, but more than is possible on the SCU [1, 2]. The IMC is not intended to replace an ICU. Of

**Table 3** Description of the level of recommendation according to the criteria by Guayatt et al [30]

1A Strong recommendation	High quality evidence, high quality RCTs, very strong data from observational studies, legal situation	Unlimited application to most circumstances
1B Strong recommendation	Good evidence, RCTs with limitations, strong data from observational studies	Unlimited application to most circumstances
1C Strong recommendation	Weak evidence, observational studies, case series, expert opinion	Could change if better evidence becomes available
2A Weak recommendation	High quality evidence, high quality RCTs, very strong data from observational studies	Can depend on circumstances, patients, social values
2B Weak recommendation	Good evidence, RCTs with limitations, strong data from observational studies	Can depend on circumstances, patients, social values
2C Weak recommendation	Weak evidence, observational studies, case series, expert opinion	Very weak recommendation, other alternatives could be equally beneficial

# Intermediärvårds rekommendationer

- Omfattande graderade rekommendationer
  - Organisatoriska(integrerad, oberoende avd)
  - Antal sängar
  - Tillgänglig servis 24/7
  - Arbetssätt
  - Personantal
  - In/utskrivningskriterier mm.
    - Monitoreringsbehov > 6 ggr/d
    - Ökat vårdbehov baserat på graderingssystem(NEMS..)
    - Organspecifika

# Inskrivningskriterier

## A. Cardiac System.

- Exclusion of acute myocardial infarction [1]
- Non-ST elevation myocardial infarction, haemodynamically stable [1, 14]
- Arrhythmia, haemodynamically stable [1]
- Haemodynamically stable patient without myocardial infarction, but requiring a *temporary* cardiac pacemaker [1]
- Acute heart failure without shock (Killip Class I, II) [1]
- Hypertensive emergency without evidence of acute organ damage requiring treatment [1]

## B. Respiratory System.

- Patients with mild respiratory failure or the risk of deterioration of respiratory failure requiring close monitoring and/or intermittent respiratory support (e. g. NIV/continuous positive airway pressure [CPAP]/high flow oxygen) [1]
- Patients who require close checks on vital parameters or intensive respiratory physiotherapy (e. g. tracheal aspiration more often than 3×/day) [1]

## C. Neurological System.

- Acute neurological–neurosurgical picture with the need for frequent neurological examination or frequent suctioning of the oral cavity or positioning [1]
- Disoriented patients requiring close monitoring and examination for signs of neurological deterioration [1]
- Stable neurological patients requiring cerebrospinal fluid (CSF) drainage [1]
- Patients with chronic neurological disorders, e. g. neuromuscular disease requiring frequent care measures

## D. Poisonings and Overdoses.

- Any patient requiring frequent neurological, respiratory or cardiovascular monitoring following poisoning or overdose and that is haemodynamically stable [1]

## E. Gastro-intestinal Disorders.

- Gastro-intestinal bleeding with mild orthostatic hypotension that reacts to volume administration [1]

## F. Endocrine System.

- Diabetic ketoacidosis requiring continuous and constant intravenous insulin administration or more frequent insulin injections in the early phase once ketoacidosis has been controlled [1]
- Hyperosmolar syndrome with increased risk of coma [1]
- Thyrotoxicosis, hypothyroidism requiring close monitoring [1]

## G. Surgical Conditions.

- Postoperative patients following major procedures that are haemodynamically stable but with an increased need for volume and transfusion, caused by large fluid shifts [1]
- Stable postoperative patients but with a high postoperative risk of bleeding (e. g. following mass transfusion, taking anticoagulant therapy, bleeding at the end of the procedure)
- Postoperative patients requiring close nursing care and monitoring, e. g. following carotid endarterectomy, peripheral vessel reconstruction, V-P shunt revision, kidney transplant

## H. Other.

- Treated and regressing sepsis without shock or secondary organ failure [1]
- Patients requiring close monitoring of fluid management [1, 20]
- Obstetric patients during pregnancy or post-partum with (pre)eclampsia or other medical problems [1]
- Any patient requiring frequent monitoring or very complex wound management that does not fall into any of the above categories (e. g. Addisonian crisis, acute renal failure, delirium tremens, hypercalcaemia)

# Ej lämpliga

## Exclusion criteria

The following conditions are usually not suitable for admission to an IMC. These should also be locally defined and may vary depending on the equipment on the unit, the experience of the treatment team, the type of patient or the disease condition.

- Acute ST-elevation myocardial infarction, acute coronary syndrome with haemodynamic instability, temporary pacemaker, haemodynamic instability of other cause, pulmonary oedema with the risk of an indication for intubation or the risk of heart rhythm disorders [1, 21]
- High catecholamine requirements or sharply varying/increasing dose, drugs requiring extensive haemodynamic monitoring
- Acute mechanical circulatory support [20]
- Patients with shock (septic, haemorrhagic, cardiogenic, anaphylactic) [20]
- Acute dialysis, continuous renal replacement therapy (CRRT)
- Patients with acute respiratory failure that have recently been intubated or in whom intubation may be required [1]
- Patients with an endotracheal tube
- Patients requiring extensive invasive haemodynamic monitoring (PiCCO, pulmonary artery or right atrial catheter or similar) or cranial pressure measurement [1, 20]
- Patients in status epilepticus [1]
- Patients with elevated cranial pressure [20], subarachnoid haemorrhage (SAH) with vasospasm [20]

## Transfer/discharge criteria

- If the patient's condition does not require intensive monitoring and treatment is possible on an SCU [1]
- If the patient's condition has deteriorated to the extent that active organ replacement is required or probably required, transfer should be made to the ICU based on a unit-specific protocol [1]

# Ska vi revidera våra riktlinjer?



# Ska vi revidera våra riktlinjer?

- Fyller nuvarande riktlinjer en funktion lokalt? Vilken? Exempel?
- Är riktlinjerna kvalitetsdrivande? Om inte; kan de bli det? Hur uppnår vi detta? Vill vi de ska vara kvalitetsdrivande?
- Bör vi vara tydligare rörande intermediärvård? I så fall hur?
- Andra förslag på förbättringar?