2. Method

Data collection

Data collection took place for one month from 1st June until 30th June 2003. All patients 16 years and over admitted to a general ICU during this time were included. Patients were not included if they were admitted to a specialty specific intensive care unit such as cardiac or neurosurgical, and patients were also excluded if they were classified as Level 3 but not admitted to an ICU.

To identify appropriate patients, all participating ICUs were asked to flag each admission to the ICU during the study period. Each flagged patient was then monitored until one of the following triggers occurred:

- The patient died on the ICU - in which case extracts of the casenotes were requested, to be reviewed by an NCEPOD advisor.
- The patient was transferred to another Level 3 care facility, either within the same hospital or another hospital.
- The patient was downgraded to Level 2 care.
- The patient was discharged from the ICU.
- The patient was still alive in ICU 30 days after admission and still classified as Level 3.

Following one of the above events, clinical questionnaires were sent to the two relevant clinicians. The physician referring the patient to ICU completed one questionnaire; this questionnaire related to the pre-admission aspects of patient care. The intensive care consultant to whom the patient was referred on the ICU completed a second questionnaire; this questionnaire related to the post admission aspects of patient care and, if applicable, discharge from Level 3 care. Blank questionnaires were distributed by the NCEPOD local reporter, or an alternative contact within the ICU.

If a patient was admitted to an ICU following transfer from another hospital, data were collected only from the intensive care consultant in the admitting ICU. This was because it was not possible to match the casenotes from different hospitals.