

## Hot off the Press- Study Results

### Midwifery Unit Admission Criteria Survey

In 2018-19 Ceri Glenister, Midwifery MSc student, worked with us on a survey of midwifery unit admission criteria. Ceri wrote up the results for her dissertation, getting a distinction, and then worked with us to draft a paper for publication. This paper has now been published online in [PLOS One](#). We asked Ceri to summarise the results of the survey for us and tell us a bit about her experience of carrying out the study and getting her work published, and what she's up to now.



We had a fantastic 71% response rate; thank you to everyone who took part. We used national guidance, in the form of the NICE Intrapartum Care Guideline CG190, to explore and describe variation in local midwifery unit (MU) admission criteria. We categorised admission criteria as 'more restrictive', i.e. effectively excluding more groups of women from admission to the MU than NICE guidance, or 'less restrictive', i.e. admitting women to the MU who wouldn't necessarily be admitted according to NICE guidance. We also wanted to find out how many alongside midwifery units (AMUs) were the 'default' option for eligible women. The key findings were:

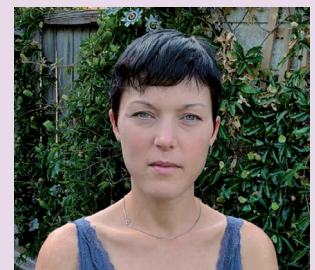
- Over half (59%) of responding NHS services reported their AMU was the default option for healthy women with straightforward pregnancies.
- Overall, 92% of local admission guidelines varied from national guidance, with 76% containing both some admission criteria that were 'more restrictive' and some that were 'less restrictive'.
- The most common 'more restrictive' admission criteria, occurring in around 30% of guidelines, excluded women who: declined blood products; had experienced female genital cutting; were less than 16 years old; or had not attended for regular antenatal care.
- The most common 'less restrictive' criteria, occurring in 40-80% of guidelines, were: explicit admission of women with parity  $\geq 4$ , aged 35-40 years, or with a BMI 30-35kg/m<sup>2</sup>; selective admission of women with a BMI 35-40kg/m<sup>2</sup>, Group B Streptococcus carriers and those undergoing induction of labour.

While there might be many understandable reasons for variation from NICE guidance, we also observed that the extent of local variation found in our survey represented a potentially confusing and inequitable picture for women and midwives. We'd be interested to hear what you think after reading the paper.



*This was a hugely rewarding study to be a part of and there was, inevitably, much more that could have been said from the data we had. One of the steepest learning curves was trying to decide how to present the findings in the way that offered the most clarity without losing too much of the detail. The experience of writing up and preparing the study for publication really made me appreciate the huge responsibility of trying to do justice to the study participants and to the data they provided.*

*I have now been practising as a qualified midwife for a year, working a split rotation between community and an obstetric intrapartum unit. I'm very pleased to see this study published and hope the findings can be used to promote further research that could improve women's experiences of making informed birth place choices, resulting in beneficial outcomes for them and their babies.*



**Ceri Glenister**  
Midwifery MSc student



## Neonatal Admission Study

Reporters who have been with us for a while will remember the Neonatal Admission Study. From March 2017 until February 2018 we used UKMidSS to identify and collect data about women who gave birth in alongside midwifery units (AMUs) and whose babies were admitted to a neonatal unit or died within 48 hours of birth without admission.



The results of this study have just been published online in [Archives of Disease in Childhood: Fetal & Neonatal](#)

The study showed that the incidence of neonatal admission (or mortality) following birth in an AMU was 1.2% and 0.01% respectively. The most common reasons for admission to a neonatal unit were suspected infection (52%) and respiratory problems (42%). Women with pregnancy complications, such as raised BMI (>35kg/m<sup>2</sup>) or GBS colonisation, were 1.4 times more likely to have their baby admitted to a neonatal unit, compared with women without these complications. Other factors associated with neonatal admission (or mortality) in these babies were male sex, nulliparity or multiparity  $\geq 2$ , prolonged or unrecorded second stage of labour, opioid use for pain relief, low birthweight (<2500g) and high (>4000g) birthweight, and shoulder dystocia. Nine babies died, six following neonatal admission, and relatively few babies had diagnoses of suspected asphyxia or meconium aspiration.

The results of this study are broadly reassuring and in line with existing evidence about the quality and safety of care in AMUs. Many of the 'risk factors' for neonatal admission or mortality we identified are known risk factors for adverse neonatal outcome in term infants born in other settings. Midwives should continue to practice in line with national guidance in relation to the management of risk factors and emerging complications in women labouring in AMUs.

 @NPEU\_UKMidSS  01865 617823  ukmidss@npeu.ox.ac.uk

