Introduction to the Labour Ward at St Mary's Hospital

The Maternity Unit at St Mary's has a delivery rate of approximately 4,000 deliveries per year. There is a 24-hour epidural service available and a Caesarean section rate of approximately 30%. The unit caters for high-risk pregnancies and the anaesthetic department is involved in many of these cases including cardiac, neurological and haematological disorders.

Please read the following and familiarise yourself with the Labour Ward before your 1st oncall

Orientation

The maternity unit is situated in the Clarence Memorial and Cambridge Wings and includes:

Alec Bourne 1 (labour ward)
1st floor Clarence Memorial Wing
11 labour rooms
HDU (4 beds)
2 Theatres
Day assessment unit

Alec Bourne 2 (antenatal and post natal ward)
2nd floor Clarence Memorial Wing
East and West Wing

Birthing Unit (Ground floor Clarence Wing)
Ground floor Cambridge Wing
Midwifery Lead

Labour ward induction for anaesthetists v1.0 28/10/2013 Drs C Mullington, A Jeeyaweera and J Bray
Location of equipment on labour ward

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidural trolley</td>
<td>In store cupboard</td>
</tr>
<tr>
<td>Airway equipment</td>
<td>Trolley in LW Theatre 1 (including GlideScope)</td>
</tr>
<tr>
<td>Resus trolley</td>
<td>Outside birthing room 7</td>
</tr>
<tr>
<td>PET trolley</td>
<td>Outside birthing room 7</td>
</tr>
<tr>
<td>Oxford HELP mattress</td>
<td>In store room opposite LW Theatre 1</td>
</tr>
<tr>
<td>Level 1 infuser</td>
<td>In store room opposite LW Theatre 1</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
</tr>
<tr>
<td>Anaesthetic drugs</td>
<td>Cupboards and fridge in LW Theatre 1</td>
</tr>
<tr>
<td>Controlled drugs</td>
<td>Main pharmacy on labour ward (midwife in charge has key)</td>
</tr>
<tr>
<td>Blood</td>
<td>2 Units of O-ve blood are kept in blood fridge on labour ward</td>
</tr>
<tr>
<td>Malignant hyperthermia box</td>
<td>Above iv fluids shelves in theatre 1</td>
</tr>
<tr>
<td>20% Intralipid</td>
<td>In drug fridge in theatre 1</td>
</tr>
</tbody>
</table>

Useful contact numbers

Anaesthetic team
- Anaesthetic SR 1201
- Anaesthetic SHO 1213
- ITU SpR 1212
- LW ODP 1672

Obstetricians
- Obstetric SR 2099
- Obstetric SpR 1101
- Obstetric SHO 2100

Labour ward induction for anaesthetists v1.0 28/10/2013 Drs C Mullington, A Jeeyaweera and J Bray
Computer and CMIS

You will each be provided with a password for CMIS. If you are not using your own password please make sure you record your name in the 'comments' section at the the end of the programme. For labour epidurals please print the labour epidural form for the midwife to use / document top-ups. A follow-up sheet will also be printed for the follow-up tray in theatre 1. For elective sections a single follow-up form will be available for printing and should be placed in the tray.

Daily activities on labour ward

Shifts:
Day shift: 08:00 - 17:00
Long day: 17:00 - 20:00
Night: 20:00 - 08:00

Handover:
Anaesthetic
Takes place daily at 08:00am and 17:00 and 20:00.
(Please handover promptly on Monday and Wednesday (07:45) so that you can attend department teaching at 08:00)
At morning handover please DO NOT handover the bleep (1211) to a CT2 (who is often covering the day) unless you have confirmed that the consultant for the day is ON SITE and contactable.

Handover should take place on Labour Ward in the office in front of the board.
Please use the black anaesthetic folder in the office with details of high risk patients and/or those under review eg PDPH
Management plans for high risk patients will be filed in this folder (Shelley Ward makes an entry in purple pen in the handheld notes if seen in high risk clinic)
Please record in this folder all
- GAs
- Accidental dural punctures
- PDPHs

Obstetric
Takes place at 08:30, 13:00, 17:00 and 20:00. These may be either ward and/or board rounds. Please make every effort to attend unless you are in theatre.

Ward rounds
- Visit rooms with epidurals running to identify any problems early.
- Review ALL patients in recovery/HDU and document in the notes on the morning ward round
- At 24:00 jointly review ALL HDU patients requiring level 2 care with the obstetric registrar. This should be a formal process which is documented in the patient notes. (This is a new recommendation following a recent SUI enquiry).

Labour ward induction for anaesthetists v1.0 28/10/2013  Drs C Mullington, A Jeeyaweera and J Bray
Elective sections
There is currently no dedicated elective section list (due to start in Jan 2014 on Tuesdays and Fridays). Currently these have to be fitted in around emergency work. On average 3 elective sections per day. All women should arrive at 07:00. They will have been premeditated with ranitidine 150 mg the night before and the morning of surgery. They should have a recent FBC and active group and save (please check)

Please do not undertake any elective work out of hours without checking with the consultant oncall.

Do not undertake any elective work if there is not the manpower to open a 2nd emergency theatre if required (during the day a ‘back up’ obstetric trainee should be identified on the rota).

Follow ups
During quiet periods please make an effort to review patients who have had anaesthetic input in the previous 24 hours. Every patient who has an anaesthetic intervention should receive follow up in the 1st 24 hours. CMIS follow up charts may be found in a draw next to the computer in theatre 1. After review, please input the data into the CMIS system.

Supervision on labour ward

In hours (8am-5pm):
Weekly anaesthetic consultant labour ward rota:

<table>
<thead>
<tr>
<th>Day</th>
<th>Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Dr Surbhi Malhotra</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Dr Shelley Ward</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Dr Jo Bray</td>
</tr>
<tr>
<td>Thursday</td>
<td>Dr Soo Lim/Dr Natalie Courtois (am) and Dr Mark Sacks (pm)(alternate weeks</td>
</tr>
<tr>
<td>Friday</td>
<td>Dr Andzrej Conn</td>
</tr>
</tbody>
</table>

High risk anaesthetic clinic run by Shelley Ward on Wednesday am in gynae outpatients

Out of hours (5pm-8am):
On call anaesthetic consultant (distant supervision)

- 5pm-9pm 2nd on consultant
- 9pm-8am 1st on consultant

Indications for calling consultant
General:
- If you are making an ITU referral and there is any bed related issue
- If you need an extra pair of hands
- If you feel you need senior advice about anything

Specific:
- Severe sepsis
- Suspected epidural haematoma
**Policies/Guidelines**

Summarised below are some of the SMH maternity policies/guidelines. This is not an inclusive list! Full guidelines may be found on the hospital intranet in the Imperial Maternity Policies and Procedures section. Please familiarise yourself with these maternity guidelines before your first oncall.

**Accidental dural puncture**

**Signs and symptoms**

Headaches are common after labour and not all headaches are dural puncture related. However, any woman suffering headache post-labour and anaesthetic intervention should have it excluded. A spinal headache is characterised classically by a throbbing frontal or retro-bulbar pain which is relieved by lying flat and IVC compression and worsened by sitting or standing, it may be accompanied by occipital pain, neck-ache and tinnitus. However, all sorts of neurological symptoms have been ascribed to Dural tap and cured by blood patching, therefore an atypical presentation may well occur.

**Management at time of puncture**

Treatment of a dural puncture begins at the time of the puncture:

- Inform patient and midwife that a dural puncture has occurred.
- After dural puncture DO NOT pull out the Tuohy needle - Try not to drain more than a few ml of CSF (cerebral spinal fluid). Consider threading epidural catheter into the sub-arachnoid space (if safe).
- Approximately 2cm should be threaded into the sub-arachnoid space.
- Label as spinal catheter.
- Each top-up should be done by the anaesthetist.
- Top-up doses are 2-3 ml of the standard low-dose mixture in incremental doses. Remember the dead space in the catheter and filter is 1 ml.
- After delivery remove catheter as usual.
- If the Tuohy needle is withdrawn, resite the epidural a space higher or lower (this may be the preferred option).
- Treat as a normal epidural, but each top-up should be given by the anaesthetist. REMEMBER EACH DOSE IS A TEST DOSE.
- There is no indication for assisted instrumental delivery.
- The Consultant Obstetric Anaesthetist must be informed ASAP (in working hours).
- Enter the women’s details into the ‘high risk/follow up’ folder on labour ward (St Mary’s).
- If there is any doubt whether the fluid seen flowing back through the epidural needle is CSF or saline, the temperature can be assessed on the back of the anaesthetist’s hand (with gloves removed), and other tests can be performed using a urine dipstick (see full guideline for details).

**Analgesia following Caesarean section**

- Please use the prescription stickers (found in theatre 1 on wall above computer) and stick in drug chart.
- Please chart enoxaparin for 20:00 or 08:00 (if LSCS after 17:00).
- Codeine is now NOT recommended postnatally.

Labour ward induction for anaesthetists v1.0 28/10/2013  Drs C Mullington, A Jeeyaweera and J Bray
The standard prescription is:
- Paracetamol 1g po qds (1 iv dose given in theatre)
- Diclofenac 100 mg pr (2 doses post theatre 12 hours apart)
- Ibuprofen 600mg qds (3 days) then 400 mg qds
- Oramorph 20mg po prn

**Anti-infective use in pregnancy and breastfeeding**
- IV co-amoxiclav 1.2 g or if penicillin allergic IV clindamycin 600 mg will be given to all women at the time of caesarean section after delivery of the baby and placenta.
- A full guideline for antimicrobial use is available on the intranet.

**Regional analgesia in obstetrics**
- Requests for analgesia should be met as soon as possible and time from request for analgesia to the anaesthetist attending should not exceed 30 minutes (OAA guideline).
- If you anticipate that your response time will be longer than 30-60 minutes please attempt to find an alternative anaesthetist to attend the patient or ask the midwife to do so.

**CSE versus Epidural**
- There are two methods for producing analgesia:
  1. A Combined Spinal Epidural (CSE) needle-through-needle technique may be used. Initial rapid analgesia (including excellent sacral analgesia) is provided by the spinal injection of 2.5 milligrams of levobupivacaine and 25 micrograms fentanyl - the spinal injection provides approximately 90 minutes of analgesia. Epidural top-ups of “low dose” 0.1% levobupivacaine + fentanyl 2 micrograms per ml can then be used.
  2. A standard epidural can be sited in the usual way (i.e. without the spinal). Top-ups can then be provided, by using the “low dose mixture” : 0.1% levobupivacaine with 2 micrograms per ml of fentanyl. The first test dose should be an initial 10mls followed by a further 5-10mls at 5 mins of the low dose mixture. Further 10-15mls low dose top-ups should be charted every 30 mins PRN.

**Patchy, Missed segment, unilateral block**
1. Alter position of woman and or withdraw catheter one or two centimetres, maintaining sterility. This is indicated with a unilateral block (which most “patchy” blocks are).
2. Give up to 20mls bolus top-up of the low dose mixture.
3. Try additional volume: 10 mls of 0.9% sodium chloride and additional opiate: 50 micrograms fentanyl.
4. If these don’t work, don’t persist, re-site it. DO NOT use 0.25% levobupivacaine as this will not help the unblocked segments but will convert the already blocked area from analgesia to anaesthesia with associated motor weakness.

**Top-ups for instrumental deliveries**
- The anaesthetist should be present during ANY delivery that cannot be managed safely by the midwife and/or difficulties are anticipated.
• For instrumentals in the room: If the existing block has been working well and there is not a great degree of urgency, 15-20 mls of the top-up solution: 0.1% levobupivacaine + fentanyl 2 micrograms per ml + extra fentanyl (50-100 micrograms) will be effective.
• For instrumentals in theatre: Fast mix solution should be used (see below). This should only be given by the anaesthetist with full monitoring.

Fast Mix:
• 20 ml preservative-free lidocaine 2% + 2 ml preservative-free sodium bicarbonate 8.4% gently agitate and discard 2 mls then add + 0.1 ml adrenaline 1:1000.
Hypertension in pregnancy

**VIII. Table 5: Diagnosis and management of severe hypertension:**

**Antihypertensive treatment options**

**Communicate**
- LW co-ordinator
- Consultant Obstetrician
- Consultant Anaesthetist
- Neonatal team

**BP ≥ 160/110 checked with manual cuff x 2, 15 mins apart**

**TARGET BP = 150/80-160**

**Initiate severe PET protocol including magnesium and fluid restriction if decision made to deliver**

Start treatment with one of 3 antihypertensive treatment options of equal preference depending on the clinical situation and clinician’s preference

- **Labetalol 200mg po stat** (prior to or in absence of IV access) or IV 50mg bolus (CI asthma, pulmonary oedema)
  - Give IV 50mg bolus slowly over 5 minutes
  - 1 bolus by 40-80mg every 10 mins to a max of 200mg

- **Nifedipine 10mg po stat** (not sublingual)

- **Hydralazine**
  - Give hydralazine 5mg IV as slow bolus over 1-2 minutes. Preload antenatal women (NOT if pulmonary oedema) with crystalloid up to 500ml IV before/at the time of 1st IV bolus.
  - Repeat every 20 mins to a max of 15mg (3 doses) as long as no side effects – see below

If decision has been made to deliver

- **Hydralazine maintenance infusion**
  - If repeated boluses still needed after successful treatment using first three treatment boluses – infusions very rarely needed
  - 60mg hydralazine to be made up to 60mls with NaCl 0.9% (1mg/ml).
  - Run infusion at 1.0mg/hr, and by 1.5mg/hr every 15 mins as required to a max of 8mg/hr

  **STOP if**
  - Diastolic ≤ 90 mmHg
  - Heart rate ≤ 120
  - Significant SE: headache, flushing

- **Labetalol maintenance infusion**
  - 20mg/hr doubling every 30 mins to a max of 160mg/hr
  - Dilute 200mg labetalol up to 50mls with NaCl 0.9%.
  - Start the infusion at +0mg/hour, doubling every 30 mins to a max of 160mg/hr

  **STOP if**
  - Diastolic < 90 mmHg
  - Heart rate < 60 bpm

If BP not controlled on labetalol or if side effects, change to nifedipine, or if decision to deliver change to hydralazine

- If BP ≥ 160/110 after 30 mins give further 10mg nifedipine po stat

If BP not controlled on hydralazine or if side effects change to labetalol or nifedipine

**Deliver if indicated or start long-term oral antihypertensive therapy**

- Decide mode of birth according to clinical circumstances and woman’s preference
- Regional anaesthesia is appropriate if platelets > 50 x 10⁹/L
VIII. Table 6: Management of severe hypertension: assessment, diagnosis and fluid balance

**BP>160/110**

- Initiate severe PET protocol and admit to LW/HDU
- Communicate and inform:
  - LW co-ordinator
  - Consultant obstetrician
  - Consultant anaesthetist
  - Neonatal team

**IV access**
- Continuous CTG
- BP every 15 mins
- Fluid in/output
- Bloods 4-12 hourly
- Use MEOWS chart
- NBM
- Ranitidine 150mg po+
- Metoclopramide 10mg po

**Give seizure prophylaxis in all women with severe PET once decision made to deliver**

**Automated BP devices may underestimate BP**

**Initiate antihypertensive treatment (see table 5)**

**FLUID BALANCE**

**General measures:**
- Record fluid balance hourly
- Total input (including all infusions) = 80ml/hr
- Use crystalloid e.g. Hartmanns

**If urine output <100ml/4hr:**
- Get senior obstetric + anaesthetic review
- Consider 200ml fluid challenge
- Monitor USE’s

**Indication for a CVP line:**
- Oliguria (<100ml/4 hrs) with impaired renal function
- Oliguria with pulmonary oedema
- Suspected hypovolaemia which fails to respond to a fluid challenge
- Severe blood loss
- Difficulty in establishing ongoing IV access

**Initiate protocol if:**
- Sustained BP >160/110
- Eclampsia
- Severe PET (requiring delivery)
- Deteriorating clinical/blood picture
- HELLP

**Stop any anticoagulation/antiplatelet treatment e.g. aspirin, tinzaparin**
IX. Table 7 - Management of severe hypertension: Eclampsia:
Seizure prophylaxis and treatment

ECLAMPSIA

Woman at risk of fitting

Get HELP
- LW co-ordinator
- Obs SPR
- Anaesthetic SPR
- Consultant obstetrician
- Consultant anaesthetist
- Neonatal team

BP ≥ 160/110 and or one of the following:
- Severe headache
- Visual disturbances
- Epigastric pain
- RUQ tenderness
- Sustained clonus
- HELLP syndrome
- Platelets < 100 x 10⁹/L
- Abnormal LFT's

Decision to deliver based on maternal + fetal assessment

IV MgSO₄, 4g loading over 15 mins
- Draw up 40ml of 1g in 10ml MgSO₄, no further dilution is required
  (Relatively CI and smaller doses may be needed with cardiac disease and acute renal failure)

Monitor:
- Cardiac monitoring
  - RR (aim for > 16 min )
  - UO (aim for > 25ml/hr)
  - Patellar/Biceps reflexes

Signs of toxicity:
- Loss of deep tendon reflexes
  (6mmol/L)
- Respiratory arrest
  (6 – 7.5 mmol/L)
- Cardiac arrest
  (> 12mmol/L)

If seizures recur despite MgSO₄:
- 2g MgSO₄, IV bolus over 5mins (withdraw
- 2g = 20ml of 1g in 10ml
- Ensure Joint obs/anaes management
- If reflexes again consider diazepam 10-20mg
- IV or preferably intubation to control seizures and protect airway
- Consider CT head once stops fitting

Withhold further doses until above normal
Send urgent MgSO₄ level to lab
Treat significant resp.depression with 1g
Calcium gluconate
(10ml 10% IV) over 10mins
Major obstetric haemorrhage

**MAJOR OBSTETRIC HAEMORRHAGE PROTOCOL**

**Actual or anticipated loss of >20% blood volume (approx 1500mls in average pregnant woman) within 3 hours or 150ml/min**

Call 2222. State "Major Haemorrhage". Give Hospital and Location

- **CHARING CROSS**
  - Monday-Friday: 9am-5pm
  - Ext. 17112
  - Out of hours: Bleep 8160

- **HAMMERSMITH**
  - Monday-Friday: 9am-5pm
  - Ext. 34772
  - Out of hours: Bleep 3122

- **ST MARY’S**
  - Monday-Friday: 9am-5pm
  - Ext. 22043/ Ext. 21157
  - Out of hours: Bleep 1611

**Information needed by the Blood Transfusion Laboratory**

- Major haemorrhage protocol being activated
- Patient Identification – Hospital/A&E Number, name & date of birth (unknown if in A&E)
- Patient location
- Name and contact details of person activating protocol for ongoing communication
- Cause of bleeding
- How urgently (in minutes) until blood is needed at the bedside
- Group & screen, full blood count & coagulation screen samples being sent

**The Blood Transfusion Laboratory will issue**

- **Immediately:**
  - Emergency O negative blood 2 units maximum (if required)
  - OR 5 units of group specific blood (begin with O negative if no blood group known)
  - OR 6 units crossmatched blood - it currently valid sample available
  - 4 units of FFP aiming to administer 1.5 RBC : 1 FFP

- **Once these components are collected from the laboratory**
  - A further 6 units of blood and 4 units of FFP will automatically be prepared and made available for issue

**At this stage consider requesting**

- 1 pool platelets
- 2 pooled units of cryoprecipitate

**THE LABORATORY WILL CONTINUE TO ISSUE 6 BLOOD & 4 FFP AT A TIME Whilst THE PATIENT IS BLEEDING ENSURE THE PORTER IS SENT TO COLLECT BLOOD AND BLOOD COMPONENTS**

**The clinical area will**

- Nominate a Blood Coordinator to ensure blood & blood components are managed effectively
- Send full blood count & coagulation screen samples as a baseline and hourly thereafter
- Send repeat group & save sample if requested
- Ensure ISS informed of need for emergency Porter (if Porter not arrived following 2222 call)
- Ensure the patient’s Consultant has been informed (if not already aware)
- Discuss on-going management with the Haematology SpR (contact through switchboard if contact details not known)
- Inform the Blood Transfusion Laboratory of the patient outcome, destination if moved and when to stand down

---

Labour ward induction for anaesthetists v1.0 28/10/2013

Drs C Mullington, A Jeeyaweera and J Bray
I) Guideline Summary

Pathway of care for APH

1. Call for help and initiate resuscitation
   - Airway: 100% oxygen and mask/bag
   - Circulation: left lateral position and 2 IV lines (14G)
   - Take blood for FBC, clotting and crossmatch 6 units

2. Listen for fetal heart sounds

3. Intensive monitoring throughout and keep the patient warm
   - Urinary catheter (hourly measurements)
   - Pulse, BP, RR, temp, and oxygen saturation
   - Consider a CVP line (hazardous if DIC)
   - Monitor for clotting disorders (and treat)
   - Monitor for hypoglycaemia (and treat)

4. If no heart sounds confirm fetal death with ultrasound and exclude placenta praevia

5. If alive consider immediate delivery
   - Caesarean section may require GA

   - Placenta praevia
     - Ruptured uterus
     - Induce labour

   - No Placenta praevia
     - Watch for PPH

   - If cloting disorder present give warmed fresh blood, FFP, cryoprecipitate
     - Platelets are rarely needed
     - Consult haematologist re other products

It is the APH that weakens and then the PPH that kills. Attention should constantly focus on resuscitation to maintain the circulation.
Severe sepsis

- Sepsis is often sinister and pregnant women with sepsis can deteriorate and die rapidly after the onset of symptoms. It is vital that prompt recognition, stabilisation and treatment of the underlying cause are initiated to avoid the rapid escalation of deterioration that leads to cell death and, ultimately patient death.
- Within obstetrics maternal death from sepsis has risen rather than declined. It is the leading direct cause of maternal death this triennium 2006-2008 (CEMD2011). The diagnosis of sepsis is not always straightforward and due to the altered physiology that takes place in pregnancy early signs may be obscured.

Clinical signs indicative of sepsis consist of one or more of the following

- Pyrexia, hypothermia or swinging pyrexia

Labour ward induction for anaesthetists v1.0 28/10/2013     Drs C Mullington, A Jeeyaweera and J Bray
- Tachycardia
- Tachypnoea
- Hypotension
- Low saturation and hypoxia
- Oliguria
- Impaired conscious level
- Failure to respond to implemented treatment

Clinical symptoms associated with sepsis (can be non-specific)
- Diarrhoea or vomiting
- Cough
- Rash
- Abdominal pain
- Rigor
- Offensive discharge
- Urinary symptoms

Management of sepsis
All women suspected or identified with sepsis should be managed initially within the obstetric high dependency unit
- Blood cultures should be obtained before administration of antibiotics however it should not prevent timely administration of antimicrobial therapy
- Broad spectrum antibiotics should be administered within one hour of suspicion or identification of sepsis
- Measure serum lactate also send blood for CRP, FBC, LFT’s U&E’s and consider ABG’s
- Administer prescribed intravenous fluids
- In the presence of hypotension and/or a serum lactate >4mmol/l crystalloids or equivalent should be administered at 20ml/kg
- If hypotension has not responded to fluid resuscitation consider vasopressors to maintain a mean arterial pressure of (MAP) >65mmHg
- If hypotension is persistent despite fluid resuscitation and/or serum lactate is >4mmol/l consider central venous pressure monitoring to achieve CVP of ≥8mmHg
- Aim to achieve a central venous oxygen saturation (ScvO2) ≥70% or mixed venous oxygen saturation (ScvO2) ≥65%

Further management
- Administer O2 therapy if saturation <93% give 15lts via reservoir mask
- Culture areas that maybe focus of infection i.e. urine, LVS, HVS, wound, throat, sputum, MRSA screen
  - Discuss all cases with microbiologist – this must be done swiftly in cases of penicillin allergy
- Insert urinary catheter and monitor hourly aim for ≥0.5ml/kg/hr
- Consider 12 lead ECG
- Consider any relevant imaging to confirm source of infection
• If a group A streptococcal infection is suspected or confirmed, the woman must be placed in a side room and contact precautions should be applied for up to 48hrs following effective antibiotic therapy. The infection control team must be informed.
• Consider insertion of arterial line for accurate haemodynamic monitoring and blood sampling
• Red packed cells may be considered when haemoglobin falls to <7.0g/dl aim for Hb of 7.0-9.0g/dl

**THANKYOU FOR TAKING TIME TO READ THIS INDUCTION INFORMATION. WE HOPE YOU WILL ENJOY YOUR TIME WORKING ON LABOUR WARD AT ST MARY’S**