Postnatal care and the 6–8-week check

Community midwifes are generally responsible for the care of pregnant women, often liaising with secondary care when problems arise, meaning that primary care clinicians are now less involved in antenatal management. Postnatally, however, the care of mother and baby returns to the GP practice, and this usually happens at the 6–8-week check. From 2020, this has been funded within the GP contract in England.

The 6–8-week check appointment may be the first time we have met a new parent and baby, and its main purpose is to identify and address any problems that may have surfaced – in either mother or baby – since birth.

Many practices are now offering the maternal check at a separate time to the baby check, as suggested by the RCGP Perinatal Mental Health Toolkit. This may offer a more conducive consultation for the mother to discuss her issues without having to care for the baby at the same time (*see Perinatal mental health* for more information).

In its 2021 guideline on postnatal care, NICE (NG194) describes WHAT we should cover in this consultation (spoiler alert: it's a lot!). In this article, we have also used articles in the BMJ and RCGP InnovAiT journal which give more specifics on HOW we approach and manage potential issues (BMJ, 2019;367:l6482; InnovAiT,2020;13(9):534).

Why is providing postnatal care important?

Although childbirth is pretty safe in the UK, we should be aware that perinatal maternal and neonatal mortality is significantly higher in ethnic minorities and women living in deprived areas, and risks may extend into the postnatal period.

We should strive to address this disparity by ensuring that we pick up on and act on social needs, and communicate effectively (using appropriate interpreters where necessary) when delivering care.

Women who may need additional support include:

- Women who misuse drugs.
- Recent migrants, refugees, asylum seekers or women with language difficulties.
- Women <20y.
- Women who experience domestic abuse.

Maternal 6–8-week check: what to cover

NICE states: "one of the key principles of care in the postnatal period is to listen to women and be responsive to their needs".

Both parents may be present at the consultation and be involved in the baby's care, and therefore should be *included* in the consultation. The table below includes a (long) list of issues that we should ask about during our (short!) consultation; some of it may not be relevant, or can be addressed at a later date if not urgent. Many practices now separate the maternal and baby checks into separate appointments, which can make it easier for the mother to discuss issues she is experiencing without having to simultaneously attend to the needs of the baby (RCGP Perinatal Mental Health Toolkit).

Remember: address any parental concerns first!

NICE on postnatal care (NG194, 2021) and BMJ, 2019;367:l6482	
Ask about...	**Advice and management options (if indicated)**
Mental health	
• Psychological/emotional wellbeing: how is she finding parenthood? Any worries? The RCGP suggests (more on this in our article on *Perinatal mental health)* that we consider non-judgemental ways of opening	• Discuss sleep hygiene and coping strategies for fatigue. • Liaise with health visitors.

the conversation about feelings. Two great questions are: **"Has motherhood been what you expected?"** **"How was the birth?"** • Sleep deprivation. • Family or other support and home environment. • Any ongoing financial or social issues. • Birth experience and any persistent negative feelings (even 'normal' births can leave a woman feeing traumatised).	• Consider perinatal mental health services if indicated. • Arrange further follow-up if concerned. **Be vigilant for any safeguarding concerns and act on these!**
Perineal and wound care	
• Wound healing issues or persistent pain (whether perineal or Caesarean section). • Abnormal vaginal discharge or bleeding. • Dyspareunia.	If symptomatic: examine to rule out infection or other pathology. <u>Persistent perineal pain:</u> • May be associated with depression or acopia. • Is more common following episiotomy/tear, assisted delivery, traumatic birth experience or wound infection/breakdown. • Advise about wound care and adequate pain relief. • Refer back to secondary care if persists. **Be vigilant for FGM and act on this.**
Continence and pelvic floor	
• Bladder function (any leakage with coughing/sneezing?). • Prolapse issues (any vaginal bulge or dragging sensation?). • Bowel problems (constipation or incontinence?).	• Investigate and manage any bowel/bladder issues. • **Remind all postnatal women about the importance of doing pelvic floor muscle exercises!** • Refer to women's health physio if needed.
Breast issues	
• Nipple discomfort. • Symptoms of mastitis. • Feeding issues.	Examine and manage accordingly (*see article on Breastfeeding: benefits and problems for more info*).
Sexual problems and contraception	
• Ask about sexual activity. • Resumption of menstruation (advise that breastfeeding suppresses menstrual cycle but not necessarily ovulation). • Use of contraception. • Check smear history (if due, this can be done around 12w postnatal).	If sex is painful, a lubricant may help. Discuss and offer hormonal contraception if required: • Breastfeeding is not a contraindication to any contraception. • **LARC methods are the most effective** (a woman may require a bridging method until the LARC can be fitted).

Medical factors	
History of pre-eclampsia.	Recheck BP and dipstick urine, and reconsider ongoing need for medication if still taking antihypertensives.
History of gestational diabetes mellitus.	• Offer fasting blood glucose (women with gestational diabetes stop their treatment immediately after birth). • Annual HbA1c is recommended due to increased risk of type 2 diabetes.
Any systemic symptoms?	Most serious perinatal complications would have presented before the 6-week check but: • Be vigilant for thromboembolic disease or infection. • Look for previous anaemia (when was the last FBC? Consider repeating, especially if still taking iron supplementation).
Vaccinations.	If non-immune to Rubella, offer MMR.
Lifestyle advice	
Smoking, alcohol and recreational drugs.	• Signpost to smoking cessation resources. • Advise against alcohol or drug use, especially if breastfeeding.
Healthy diet and supplements.	• Encourage fruit and vegetable consumption (some families may be eligible for the Healthy Start voucher scheme; see useful resources, below). • **Breastfeeding women should take 10mcg (400IU) vitamin D daily.**
Exercise.	Helps with: • Mental wellbeing. • Physical fitness. • Weight loss. • Good sleep. Start low-impact exercises (e.g. brisk walking) when feels ready – typically within 2w after vaginal delivery and 6w after Caesarean section. The Chief Medical Officer advice is to aim for: • 150 minutes of moderately-intensive activity per week. • Muscle strengthening activities 2x a week. • Fitness to be built up gradually. taking into consideration energy levels, other health issues and circumstances postnatally.

6–8-week baby check: what to cover

First, address any parental concerns about baby's wellbeing, feeding or development, and deal with any acute illness. Then go through the following (documenting any positive findings in the child's personal child health record or 'red book').

NICE on postnatal care (NG194, 2021) and InnovAiT,2020;13(9):534
Birth history and any perinatal problems
Check discharge summary from hospital and ask about any antenatal, birth or perinatal problems. Ask about development. Is baby: • Smiling? *Eliciting this at the start may establish a rapport and help everyone relax!* • Responding to noise? • Visually fixing and following? Has contact been made with the health visiting team? (this usually happens around 6–8w, after midwife involvement has ceased). **Encourage parents to attend for routine childhood vaccinations.**
Examination
Appearance: colour, behaviour, activity and posture. Is there a normal cry?
Head Check: • Fontanelles: these should be soft and concave. The posterior fontanelle closes around 6–8w and the anterior one between 9–18m. Refer suspected craniosynostosis (premature fusion of skull sutures) to specialist. • Shape: brachycephaly (unilateral flattening) or plagiocephaly (posterior flattening) is usually self-limiting. • Face: any dysmorphic features; check mouth (for cleft palate).
Eyes • Check colour of sclera, shape of eyes and symmetry. • Elicit red reflex (absence may suggest congenital cataracts or retinoblastoma, so refer urgently if concerned). • Look for visual fixing and following.
Musculoskeletal • Check neck and clavicles: any bony abnormality or callous formation may indicate an undiagnosed clavicular fracture. • Examine limbs, hands, feet and digits. • 'Clubfoot' (congenital talipes) presents with a plantar flexed foot, with the forefoot adducted so the sole rotates postero-medially (in and under). Refer orthopaedics. **Hip examination** (to rule out developmental dysplasia of hips (DDH)) • Lie baby supine and look at leg length and symmetry. • **Barlow's manoeuvre** (for hip instability): examine one leg at a time, stabilising contralateral hip. Flex and adduct hip, and apply positive pressure downward onto knee. If the hip dislocates posteriorly (felt as a pop), this is positive. • **Ortolani's manoeuvre** (reduces dislocation): place index and middle finger over greater trochanter, and thumb near the groin crease; gently abduct thigh and apply upward pressure to the trochanter; if the femoral head relocates into the acetabulum, then a 'clunk' is felt and this is confirms DDH. • Refer urgently to paediatric orthopaedics if above tests are positive, or if there is any limited abduction of either hip.

Note: isolated clicks in an otherwise normal hip examination are not worrying, but seek specialist advice if unsure.

Heart

- Auscultate for rate, rhythm and sounds: check aortic, pulmonary, tricuspid, mitral and infrascapular areas.
- Pathological murmurs tend to be loud, diastolic, continuous, heard over a wide area and may be associated with other features (e.g. cyanosis, respiratory distress, failure to thrive).
- A soft systolic murmur heard at the left sternal edge in a well infant is likely to be benign. BUT, if doubt remains, refer.
- Assess femoral pulse volume.

Lungs

- Respiratory rate, effort and lung sounds.

Abdomen

- Check umbilical stump, and for organomegaly.
- Look for hernaie: inguinal herniae require referral for repair; umbilical herniae should be monitored and only require surgery if persist at 3y.

Genitalia and anus

- Check for normality and palpate testes. Refer any abnormalities (e.g. hypospadias).

Skin

- Check for unusual birthmarks or rashes. Note any Mongolian blue spots as they can be mistaken for bruises later on.

Central nervous system

- Assess general tone and movement.
- Lay baby on their front and assess truncal tone – they should be able to hold head in line with the body.
- Inspect spine structure and overlying skin for hair tufts/haematoma to check for spina bifida occulta. If presence of a sacral dimple in a child with any abnormal neurology, cutaneous stigmata, or if the dimple is >5mm in size or >25mm away from the anus, we should refer for lumbar spine ultrasound (or to paediatrics)
- Only do reflexes if concerned.

Measure

Head circumference

Measure the widest part of the head, usually above eyebrows anteriorly to occiput posteriorly. Some babies have big heads! BUT any large discrepancies from previous measurements should be referred to rule out hydrocephalus (especially if any other concerning features).

Weight

If there are any signs of faltering growth:

- Discuss any feeding issues.
- Arrange weekly weighing.
- Refer if persists.

Record findings on the growth chart in the ‘red book’.

Feeding advice

Vitamin supplements

- Babies from birth to 1y should have a daily supplement of 8.5–10mcg (340–400IU) of vitamin D if they are breastfed or having less than 500ml of infant formula a day (as formula is fortified with vitamin D).

- Children aged 1–4y should take Healthy Start vitamins daily. These contain 10mcg (400IU) of vitamin D, as well as vitamin A and C (Healthy Start – healthcare professionals).

Breastfeeding

- Ensure this is established and address any ongoing issues *(see article on Breastfeeding: benefits and problems for more information).*

Bottle-feeding

- Advise that 'first infant' formulas can be used for the first year.
- Babies feed for love, comfort and reassurance, so it is possible to 'overfeed'.
- Ensure parents know how to pace feeds and respond to feeding cues, e.g. hold baby close, eye contact, not forcing baby to finish bottle.

Advice about bed-sharing

Share the following advice:

- Make sure baby sleeps on a firm, flat mattress and lies face up.
- Do not sleep on a sofa or chair with baby.
- Do not share the bed with a pet or another child as well.
- Avoid bed-sharing if baby was a low birth-weight baby.
- Do not bed-share after consuming alcohol, recreational drugs, sedatives or after smoking.

Promoting emotional attachment

Bonding and emotional attachment develop through innate, positive, complex interactions between parent and infant. If there are challenges with this, we should:

- Explore any factors which may be impeding this connection (e.g. maternal recovery from physical or emotional trauma of birth, sleep deprivation and fatigue, medical or developmental issues with baby).
- Encourage face-to-face interaction and skin-to-skin contact.
- Discuss appropriate response to baby's cues (whether hungry, tired, seeking proximity to parent), and how to comfort and soothe.

Some parents may have more psychosocially complex needs and need additional support.

How do I cover all of this in the time allotted?

Like much of our work in primary care, these consultations have the potential to be complex and to overrun. An editorial in the BJGP points out that the NICE guidance identifies at least 25 topics that may need to be covered in the maternal check alone. This runs the risk of some issues being missed. Prioritising, signposting and safety-netting are important tools to use in ensuring that patients' needs are met.

The article also suggests that adequate time (and training) is allocated to complete these comprehensive and important consultations well, and provide holistic and satisfactory care (BJGP, 2021;71(710):394).

	**Postnatal care and the 6–8-week check** • The purpose of the 6-8-week check is to identify and address any problems that may have surfaced or been missed – in either mother or baby – since birth. • We should be mindful that perinatal maternal and neonatal mortality is significantly higher in ethnic minorities and women living in deprived areas, and risks may extend into the postnatal period. • The maternal check includes addressing any physical, emotional or psychological issues, and giving ongoing lifestyle advice to optimise health. • The baby check includes managing any ongoing issues raised by the parents, and a full examination to pick up any physical or developmental problems. • The 6–8-week check may raise multiple issues affecting mother and baby, so we should prioritise, signpost and safety-net to ensure that we give holistic and safe care.
	**Useful resources:** Information about the healthy start voucher scheme: https://www.gov.uk/healthy-start Web address for the pelvic floor exercise support app: https://www.squeezyapp.com/