Overcoming tongue-tie

In the second part of the series, Valerie Finigan shares the outcomes of a one-stop tongue-tie service in a north-west England hospital.

The 1989 White Paper Working for patients sets out the need to standardise clinical audit as part of health care. The paper suggests that audit is the systematic, critical analysis of the quality of clinical care, including the way patients are diagnosed and treated, how resources are used, and the patient’s outcome and quality of life (Secretaries of State for Social Services, Wales, Northern Ireland and Scotland, 1989).

NICE (2002: 1) describes a clinical audit as ‘a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change’.

Clinical audit can be viewed as a cycle or spiral, where stages are followed in a methodical way to establish best practice and measured against criteria, in which action is taken to provide sustainable improvement. Each cycle aspires to achieve a higher quality standard. During an audit, any ethical issues must be addressed. For example, data collected must relate only to the objectives of the audit and must be respectful to confidentiality (NICE, 2002).

In the case of frenulotomy, studies of diagnosis and outcome measures are mainly subjective (Finigan and Long, 2013). On the whole, the studies are reliant on mothers’ verbal accounts of experience or on providers’ subjective assessment of tongue-tie degree and tongue mobility.

Nevertheless, the procedure clearly appears to impact on breastfeeding outcomes, as demonstrated in this audit, with frenulotomy supporting long-term breastfeeding.

Other studies have shown that, post-frenulotomy, more than 50% of mothers were still breastfeeding their babies at three months of age (Finigan and Long, 2013).

The clinical audit department at Penine Acute Hospitals NHS Trust developed a database, which is a system for later report-building in the frenulotomy service. Audit enables practitioners to answer questions and to think more widely.

For example, after the first few years of service provision, I was able to see that we were not meeting the needs of mothers who started to breastfeed, but had moved to bottle-feeding because of the problems of tongue-tie. They often had continued feeding challenges, but our guidelines prevented us from carrying out the procedure. The findings were shown to the clinical leads and we extended the service to accept bottle-fed babies who had feeding problems too.

Retrospective audit

Between October 2007 and September 2012, 2759 babies attended for tongue-tie division. After the procedure was explained and alternative management discussed, 2590 parents decided to have their baby’s frenulum divided.

A Likert scale of 1 to 10 was used to assess any improvement in feeding and it showed that 96% of mothers reported an immediate improvement. These included more comfortable feeding, absence of pain and deeper attachment at the breast. In babies who were bottle-fed, parents reported less spillage of milk, less reflux and choking, as well as faster feeding. Two babies were fed by naso-gastric tubes and, post-procedure, they bottle-fed immediately.

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The 4% of babies who had no immediate improvement included those who were asleep and would not wake for a feed, mothers who had a low milk supply and those with very sore nipples.

After 24 to 48 hours of having the procedure, we followed up by telephone. By this time, 71% of the mothers responded positively, reporting continued improvements and resolution of feeding problems. For 29%, no improvement was reported. The reasons given included thrush in the breast, the baby continuing to need some formula milk, and an ongoing struggle for the baby to attach. However, the majority of this 29% were mothers who did not answer the call, so their experience could not be accounted for.

Another telephone follow-up took place at three months post-procedure. This was because NICE asks that practitioners providing services demonstrate the longer-term benefits of the procedure on the continuation of breastfeeding rates. In this follow-up, 21% of women responded to the call. Such a low return means that the data should be interpreted cautiously.

Of those who responded, 43% continued to exclusively breastfeed and said tongue-tie division had improved their experience. The rate of exclusive breastfeeding in this cohort of mothers was higher than that reported in the national infant-feeding survey. In that survey, only 23% said that they were exclusively breastfeeding at six weeks (Health and Social Care Information Centre and IFF Research, 2012). Indeed, a further 16 mothers said that they had continued to breastfeed for a minimum of eight weeks after frenulotomy, but stopped at this point to return to work. Three mothers had expressed and given nothing other than their own milk for six months, 12 mothers had mixed fed, and five mothers had moved to bottle-feeding.

Examples of qualitative data suggest that the service is helpful. One mother said: 'I really could not have carried on breastfeeding if this procedure had not gotten rid of the pain.' A health visitor said: 'I was at the end of my tether; I did not know how else to support this mother to breastfeed. Such a simple procedure and now she is breastfeeding beautifully.'

The future
The service is productive and preventative, having an impact on maternal and infant morbidity by supporting continued breastfeeding, which will reduce NHS costs in both the short and long term (Renfrew et al, 2012).

But, of course, no service is perfect. The audit shows that there is still a long way to go. Improvements needed include developing robust, clinically simple assessment tools for diagnosis and more objective measurements of outcomes. We also need to conduct rigorous research to identify the impact of this procedure in the short and long term on feeding, speech and language development and emotional and social wellbeing. There is also the need to strengthen the training opportunities for future service development.

These goals aside, the service has proved itself to be valuable and supportive. Without doubt, it meets the government quality agenda. The service is viewed by families and professionals as outstanding with lots of commendations. Moreover, it was innovative, as it was the first service developed in the north-west region of England to be run solely by a midwife.

Valerie Finigan
Consultant midwife for infant-feeding, Pennine Acute Hospitals NHS Trust

For references, visit the RCM website