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Royal Cornwall Hospitals NHS Trust

Tongue Tie Assessment and Management of Ankyloglossia Clinical Guideline

V3.0

June 2023

1. Aim/Purpose of this Guideline

1.1. This gives guidance to staff (midwives, maternity support workers, paediatricians, GPs, health visiting team members, maxillo-facial team doctors) when they suspect or diagnose the presence of a tongue tie (sub-lingual frenulum) which is adversely affecting the way a baby is feeding. The guideline is intended to help staff understand how this may affect the baby and parents, and the referral pathway and management options.

1.2. This guideline deals with the division of tongue ties for babies which are either outpatients or inpatients and applies to all staff involved with the procedure.

1.3. This version supersedes any previous versions of this document.

1.4. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

Tongue tie assessment and division where necessary is important due to the–

- Impact on establishing successful feeding.
- Impact on feeding parent mental health (NICE, 2005).

There is very limited evidence to suggest that early division of tongue tie clinically adjusts outcomes for speech (Ito 20 15, Baxter, 2020, Salt, 2020).

There is no evidence to suggest that early division of tongue tie clinically adjusts outcomes for digestion issues or long term dental health.

NICE Guidance therefore only recommends division when performed after conservative management has failed, in support of continuing successful breastfeeding. (NICE, 2005)

2.1. Tongue Tie should be assessed and divided (if necessary) by a midwife trained in the technique and performed in one of the following clinical spaces.

- Royal Cornwall Hospital.
- Penrice Birth Centre.
- Helston Birth Centre.

2.2. Assessment of tongue tie.

- Every feeding assessment performed on a baby is an opportunity to assess for tongue tie.
- Referral for specialist assessment is required where there are suspicions that a tongue tie is present AND **despite adequate and sustained feeding support (conservative measures taken)** is affecting the baby's ability to successfully establish feeding.
- Specialist assessment needs to be undertaken by a competent member of staff familiar with tongue tie division.
- Any infant readmitted to the acute setting for a feeding related issue: Consider tongue tie. Assess for tongue tie if competent to do so, documenting your assessment as part of the readmission Infant Feeding Assessment, including the TABBY score. If you suspect a tongue tie, refer to Infant Feeding Team for assessment for division via rcht.infantfeedingteam@nhs.net . See Management of Ankyloglossia guideline for assessment forms.
- Communication with carers/parents is key:
  - Patient Information leaflet 'Tongue Tie' should be given (RCHT 1817).
  - Clear signposting to feeding support.
  - Conversation that ensures carers/parents understand that not all tongue ties will affect the baby's ability to establish feeding (may not need division or specialist support). (Hogan, Westcott and Griffiths, 2005) (NICE, 2005).

2.3. Procedure for assessment of Tongue Tie:

2.3.1. Explain to parents what the examination involves and obtain verbal consent.

2.3.2. Wash hands thoroughly and dry them.

2.3.3. Ensure fingernails are short and clean, personal protective equipment may be used.

2.3.4. Ensure good lighting.

2.3.5. Sweep index finger gently across underside of tongue, feeling for a band of tissue, and visually examine underside of tongue.

2.3.6. If a tongue tie is found, observe feeding, ensuring optimal positioning and attachment, and give support with achieving effective feeding if necessary.

2.3.7. If the tongue tie appears at or close to tip of tongue, or if baby appears unable to extend tongue enough to achieve effective milk removal, test the ability of the baby to suck on finger of examiner, with pad of little finger in roof of baby's mouth and baby's head extended. If tongue movement is impeded, the examiner will be able to feel baby's lower gum ridge across back of examiner's finger.

2.4. Referral of baby with Tongue Tie.

If tongue tie is affecting feeding, refer for assessment by an experienced practitioner.

2.4.1. Criteria for division of tongue tie by registered midwife/ nurse at Royal Cornwall Hospital Trust requires that a baby should be:

- Ideally over 24 hours.
- Under 12 weeks old.
- Partially or fully breastfeeding.
- Risk assessment performed of full clinical history prior to procedure.
- Full feeding assessment has been performed and documented.
- Baby's clinical history reviewed with regard to prophylactic administration of Vitamin K and for family history of clotting disorders.
- A full course of oral vitamin K, i.e., 2 doses of 2mg oral vit K if baby is <1month or 3 doses of 2mg if baby >1month, or a single dose of intramuscular (IM) vitamin K is required prior to tongue tie division.
- If intra venous (IV) vitamin K has been given a second dose – either IM or oral is required prior to tongue tie division.
- If vitamin K has not been given more than 12 hours prior, then do not perform a frenulotomy.
- Do not perform frenulotomy on babies who are known to have low or abnormal platelet levels.

2.4.2. Liaison with the Infant Feeding Team via email rcht.infantfeedingteam@nhs.net will ensure a timely appointment.

2.4.3. If the baby is over 12 weeks old or if the practitioner is not confident that the division is straightforward refer via Maxims to the Oral Maxillo/ Facial team.

2.5. Procedure for dividing tongue tie (by a trained professional):

2.5.1. Ensure primary carer has received, understood, and had the opportunity to ask questions about the information provided on Tongue Tie in the Tongue Tie Leaflet.

2.5.2. Use BRAIN acronym with parents for making an informed choice about whether to divide the tongue tie or not.

2.5.3. Assessment and consent for this procedure should be documented using the triplicate Assessment of Tongue Tie form. The white copy is retained by the primary carer and can be filed in the baby's Personal Child Health Record (Red Book). The pink copy should be returned to the Infant Feeding Team for filing in the Tongue Tie division folder. The Yellow copy should be stored in the baby's notes if available at the time of assessment/division or sent to the baby's GP.

2.5.4. Each clinic has a PAS code, and all procedures must be entered under the correct code.

2.5.5. Electronic notes should be used to document the tongue tie assessment and division if the baby is under midwifery care.

2.5.6. Practitioners performing division should document the Bristol Tongue Assessment Tool (BTAT) score using the TABBY tool (visual version) on the assessment form (See Appendix 5 for BTAT and TABBY tool).

2.5.7. Explain procedure to parents, including discussion of appearance of site after procedure, healing process and analgesia as appropriate.

2.5.8. Check for family history of bleeding/clotting problems and discuss Vitamin K prophylaxis at birth.

2.5.9. Obtain informed written consent for procedure using the Tongue Tie Assessment Form.

2.5.10. Wash and dry hands thoroughly.

2.5.11. Try to ensure procedure is being done around a feed, so that suckling action acts as a form of analgesia. A breastfeed, amount of expressed breastmilk or oral sucrose 24% solution can be used in advance of the procedure to pain management as appropriate.

2.5.12. Prepare a clean flat surface with a mat, or a cot for the baby with a blanket to wrap the baby in.

2.5.13. Prepare sterile scissors (curved blades/ blunt tip) and sterile gauze swabs.

2.5.14. Prepare non-sterile latex free gloves for the practitioner.

2.5.15. If parent/carer is not happy to hold the baby for the procedure, ensure that a colleague is available to assist (parents/ carers should ideally be present for the procedure.

2.5.16. When baby is approximately halfway through a feed, and is settled and content, wrap the baby's body in the blanked so the baby's hands are secured away from the baby's face.

2.5.17. Wash and dry hands. Put gloves on.

2.5.18. Lay baby on mat, and position parent/assistance at baby's head and place their hands on baby's shoulder, head between the wrists.

2.5.19. Divide tongue tie in accordance with training.

2.5.20. Lift baby up and settle if distressed.

2.5.21. Check for bleeding and apply pressure with a gauze swab moistened with sterile water or breastmilk if necessary.

2.5.22. Once baby is calmed and any bleeding has subsided, encourage parent to offer feed again and reassure/ answer any further questions parents may have.

2.5.23. If bleeding not settling quickly then apply 10 minutes of continuous pressure over the raw wound, then a further 10 minutes if necessary.

2.5.24. If the above conservative measures have not stopped the bleed, get a colleague to assist you to prepare sterile gauze soaked in 500mg/5ml Tranexamic Acid, get verbal consent from the parents, then apply soaked gauze to the wound continuously for 2 minutes.

2.5.25. If this has not stopped the bleed call for paediatric assistance or, if in the community, call an ambulance stating 'the baby is not breathing normally' when asked to enable the correct response time.

2.5.26. If Tranexamic acid is used the baby must be kept in the acute unit for 4 hours post administration to be observed, then a follow up appointment within 72 hours. Complete a Datix

2.5.27. Ensure site is not bleeding after feed.

2.5.28. Ensure aftercare advice, including contact details of who they should contact if concerned, is clear. Use Tongue Tie Information Leaflet to support this discussion.

2.6. Follow up after Tongue Tie division.

Following tongue tie division, a feeding parent should have open access to the

practitioner who performed the division via telephone Signposting to onward feeding support should be given.

2.7. Training and competencies

2.7.1. Staff performing frenulotomy at Royal Cornwall Hospitals Trust must have undertaken a recognised training package or undertaken the in-house training available at Royal Cornwall Hospitals Trust. (See Appendices 3 and 4).

2.7.2. In house provision can only be provided by a member of staff who has been performing frenulotomy for 2 years and is regularly carrying out a minimum of 30 tongue tie divisions per year. Trainers would ideally be IBCLC (International Board of Lactation Consultant Examiners) trained (Lactation consultant).

2.7.3. Practitioners performing frenulotomy should attend an update training session at least once every three years. Royal Cornwall Hospitals Trust will provide such update training, and in the event of a practitioner being unable to attend this, alternative update training should be attended by the individual practitioner.

2.7.4. A list of practicing trained staff operating at Royal Cornwall Hospitals Trust is to be held by the infant feeding Coordinators.

2.8. In event of accidental injury to the tongue, with bleeding. Immediate compression with gauze. If immediate haemostasis is not achieved the care should be escalated to the Neonatal team (if a maternity / neonatal inpatient at RCHT) or paediatrics (if in the community).

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Total number of infants undergoing this procedure per year. Incidence of any complications arising from this procedure. Effect of procedure on feeding. Datix reports to be monitored individually. The following points should be audited: • Total number of babies registered for procedure on patient administration system (PAS). • Baby/parents offered appointment for assessment within 1 week (midwives) or 2 weeks (Oral Maxillo Facial Team). • Any readmissions for infection/excessive bleeding as a result of procedure (through Datix reporting). • Evaluation of feeding experience 1-2 weeks post-procedure on 1% of babies, using format in Appendix 2.

Information Category	Detail of process and methodology for monitoring compliance
Lead	Katie Hicks, Infant Feeding Coordinator.
Tool	The number of frenulotomies carried out by the training midwives annually.
Frequency	Yearly audit.
Reporting arrangements	Results will be viewed by Infant Feeding Steering Group
Acting on recommendations and Lead(s)	Any deficiencies will be identified, and an action plan developed and monitored by Infant Feeding Steering Group.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Tongue Tie Assessment and Management of Ankyloglossia Clinical Guideline V3.0
This document replaces (exact title of previous version):	Tongue Tie Assessment and Management of Ankyloglossia V2.1
Date Issued/Approved:	June 2023
Date Valid From:	June 2023
Date Valid To:	June 2026
Directorate / Department responsible (author/owner):	Janey Ashton; Infant Feeding Coordinator
Contact details:	01872 252020
Brief summary of contents:	Tongue tie assessment referral and division
Suggested Keywords:	Tongue Tie, Ankyloglossia, Frenulotomy
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Meeting
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Caroline Amukusana
Links to key external standards:	National Institute for Health and Care Excellence: IPG 149. Division of ankyloglossia (tongue-tie) for breastfeeding (2005).
Related Documents:	Bristol Tongue Assessment Tool (BTAT). https://baynav.bopdhb.govt.nz/media/2345/20170816

Information Category	Detailed Information
	-bristol-tongue-assessment-tool-btat.pdf. TABBY Tongue Assessment Tool. Hoganm M., Westcott, C., and Griffiths, D.M. (2005) A randomised, controlled trial of division of tongue-tie infants with feeding problems. Journal of Paediatrics and Child Health, 41 (5-6):246-50. Perez-Aguirre B, et al (2018) Oral findings and its association with prenatal and perinatal factors in newborns. https://www.ncbi.nlm/nih.gov/pmc/articles/PMC6172521. Mills et al (2019) Defining the anatomy of the neonatal lingual frenulum https://onlinelibrary.wiley.com/doi/full/10.1002/ca.23343. Mills et al (2020) Understanding the Lingual Frenulum: Histological Structure, Tissue Composition, and Implications for Tongue Tie Surgery. International Journal of Otolaryngology Volume 2020 https://www.hindawi.com/journals/ijoto/2020/1820978 Ferres-Amat, E,. Pastor-Vera, T., et al (2016) Multidisciplinary management of ankyloglossia in childhood. Treatment of 101 cases. A protocol. Med Oral Patol OralCir Bucal. 2016 Jan1;21(1):e39-47. Ito, Y. et al 2015 Effectiveness of tongue-tie division for speech disorder in children. Pediatrics International 2015 Apr;57(2):222-6. Baxter, R et al (2020) Functional Improvements of Speech, Feeding and Sleep After Lingual Frenectomy Tongue Tie release: A Prospective Cohort Study Clin Pediatr (Phila) 2020 Sept. Salt, H. et al. (2020) Speech production in young children with tongue tie. International Journal of Pediatric Otorhinolaryngology Volume 134, July 2020, 110035. NICE Guidance document on Tongue Tie Division https://www.nice.org.uk/guidance/ipg149

Information Category	Detailed Information
	MoniFrancis D, Krishnaswami S, McPheeters M. Treatment of Ankyloglossia and Breastfeeding Outcomes: A Systematic Review. Pediatrics. 2015;135(6):e1458-e1466. Power R, Murphy J. Tongue-tie and frenotomy in infants with breastfeeding difficulties: achieving a balance. Archives of Disease in Childhood. 2014;100(5):489-494. Segal L, Stephenson R, Dawes M, Feldman P. Prevalence, diagnosis, and treatment of ankyloglossia: methodologic review. Canadian Family Physician. 2007;53(7):1027-1033
Training Need Identified?	Yes: RCHT to put in place a staff update training event and continue to provide this every three years for staff to attend (First arranged for September 2020)
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Newborn Care

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
11.06.2013	V1.0	Initial version	Helen Shanahan Infant feeding lead midwife
14.6.2017	V1.1	No changes	Helen Shanahan

4th June 2020	V2.0	1.4. Inclusion statement. 2.1. Procedure to be performed at RCHT, Penrice BC or Helston BC. 2.2. Tongue tie check as part of NIPE check. 2.3.3. PPE. 2.4. Referal criteria, vitamin K, low platelets. 2.3.4. Oral Maxillo facial team referral criteria. 2.4.1. Information giving and sharing with primary carer. 2.4.2. Assessment and consent documentation. 2.4.3. Patient Administration System. 2.4.4. Electronic notes. 2.4.5. BTAT and TABBY tool. 2.4.8. Written informed consent. 2.4.10. Analgesia. 2.4.14. Holding baby, presence of parents. 2.4.23. Aftercare advice and tongue tie Information leaflet. 2.5. Follow up and ongoing support. 2.6. Training. 2.6.2. Provision and training. 2.6.3. Updating training. 2.6.4. Database of trained staff. 3. Element to be monitored, tool, frequency. Appendix 1, training updates.	Janey Ashton Infant Feeding Team
June 2022	V2.1	2.0- background and supporting evidence updated. 2.2- updated process for assessment of tongue tie. 2.4.1- vitamin k prophylaxis clause added. 2.8- guidance included regarding accidental injury to tongue. Addition of requirement to assess for tongue tie on all readmissions.	Dr Chris Bell Janey Ashton (IFT)
June 2023	V3.0	Vitamin K requirements added and passage regarding management of post procedure bleeding.	Katie Hicks; Infant Feeding Coordinator

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All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Tongue Tie Assessment and Management of Ankyloglossia Clinical Guideline V3.0
Directorate and service area:	Neonatal
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines Group
Contact details:	01872 252050

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide clear guidance to all practitioners in relation to Tongue Tie assessment and division
2. Policy Objectives	Ensure parents understanding of the procedure and the practitioners' responsibilities when assessing for and performing a tongue tie division
3. Policy Intended Outcomes	To ensure babies who require tongue tie revision are referred and treated appropriately
4. How will you measure each outcome?	Monitoring and compliance tool
5. Who is intended to benefit from the policy?	Practitioners who practice tongue tie division Neonates requiring tongue tie assessments and frenulotomy

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Neonatal Audit and Guidelines Group
6c. What was the outcome of the consultation?	Approved- 07 June 2023
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys: no**

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carer needs- i.e., available in different languages if required/access to an interpreter if required

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carer with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	All staff should be aware of any marital arrangements that may have an impact on care (for example: separated parents, domestic abuse).
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3: RCHT In-house Competencies for Division of Tongue Tie (Frenulotomy) in Infants Under 12 Weeks of Age

DEMONSTRATE THE ABILLITY TO:	SIGNATURE (SUPERVISOR)	PRINT NAME	DATE	SIGNATURE (PRACTITIONER)	PRINT NAME	DATE
1. Identify and describe own professional accountability						
2. Identify relevant local policies regarding frenulotomy						
3. Demonstrate an in depth knowledge of all aspects of frenulotomy, including rationale, risks, contraindications and accepted practice including BTAT scoring						
4. Discuss potential risks/complications and how to deal with these						
5. Demonstrate appropriate assessment and preparation of mother and infant and how consent is obtained						
6. Demonstrate knowledge of equipment required and use of asepsis						
7. Demonstrate correct disposal of waste, according to policy						
8. Completion documentation						
9. Demonstrate care of the infant following the procedure						
10. Identify and show understanding of research literature relating to this topic						

Appendix 4: Certificate of Competency in Performing Frenulotomy in Infants.

To be completed by training following mentorship and monitoring through Competencies for division (Appendix 3).

I have trained ……..and believe that she/he is competent to carry out this role unsupervised. I understand that she/he is responsible for maintaining her/his competence and keeping up to date. I take full responsibility for my actions in training this practitioner to take on this role, and understand she/he has the right to refuse to perform this role if she/he feels this is appropriate.

Signature: ..... Date .....

Name (print):……..

Role:……..

I have been trained and feel happy to carry out this role unsupervised. I understand that I am responsible for maintaining my competence and keeping up to date. I understand that I am required to attend a practice update a minimum of every 3 years . I take full responsibility for my actions in taking on this role, and understand I have the right to refuse to carry it out if I feel this is appropriate.

Signature: ..... Date .....

Name (print): .....

Appendix 5: BTAT and TABBY Scoring tools

TABBY Tongue Assessment Tool

	0	1	2	SCORE
What does the tongue-tip look like?				
Where it is fixed to the gum?				
How high can it lift (wide open mouth)?				
How far can it stick out?				

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Bristol Tongue Assessment Tool (BTAT)			
Elements	**0**	**1**	**2**
Tongue tip appearance	Heart shaped	Slight cleft / notched	Rounded
Attachment of frenulum to lower gum ridge	Attached at top of gum ridge	Attached to inner aspect of gum	Attached to floor of mouth
Lift of tongue with mouth wide (crying)	Minimal tongue lift	Edges only to mid-mouth	Full tongue lift to mid-mouth
Protrusion of tongue	Tip stays behind gum	Tip over gum	Tip can ascend over lower lip

The BTAT visual assessment tool was developed by Jenny Ingram, Marion Copeland, Debbie Johnson and Alan Emond at the Centre for Academic Child Health, University of Bristol, 2018. It is used with their permission