Implementing Routine Haematinic Monitoring in Long-Stay Psychiatric Inpatients: A Developing Quality-Improvement Project

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Aims

Evaluate current practice against national standards, explore barriers via staff feedback, and pilot low-resource interventions to improve detection, documentation, and follow-up of haematinic deficiencies.

Background

Haematinic deficiencies (iron, B12, folate) worsen fatigue, cognition, and mood, yet are frequently under-recognised in psychiatric inpatients. National guidance (NICE NG239 2024; BSG 2021) recommends symptom-led testing, but long-stay forensic populations face added risks: restricted diets, polypharmacy, and limited primary-care access. This project combined baseline audit with early QI work, developing a local policy for universal admission and annual haematinic screening aligned with NICE NG222 (2022) and Royal College physical-health guidance.

Methods

A retrospective review of all inpatients in a medium secure unit (n = 38) examined whether haematinics were requested, deficiencies identified, and monitoring completed. Compliance was assessed for key standards: initial screening, repeat Hb 2–4 weeks post iron initiation, ferritin at 8–12 weeks, vitamin B12 at 3 months, folate at 4 months, and B12 checked before folate therapy.

A staff survey explored perceived barriers and improvement ideas. Root-cause analysis highlighted absent review dates and unclear responsibility. A one-page "Haematinic Monitoring Prompt" was introduced into physical-health files. Additional early QI recommendations included creation of a "Psychiatric Admissions Bloods" set on the electronic requesting system (automatically including FBC, ferritin ± iron studies, B12, folate, and CRP), provision of populated bloods request forms where electronic requests were not available, and development of a concise "Haematinic Monitoring Grab Sheet" detailing how and when to repeat tests (annually or if symptomatic). Early re-evaluations occurred 2 weeks later.

Indicator	Standard	Baseline Compliance	Post-prompt
Admission haematinics completed	**>95%**	**53%** (20/38)	**100%** (2/2)
Deficiency identified	-	**37%** (14/38)	-
Appropriate follow-up for deficiencies	**>90%**	**21%** (3/14)	Data awaited
Monitoring responsibility documented	**>90%**	**14%** (2/14)	**100%** (2/2)
Reason for testing documented (if not at admission)	-	Rare – 2 cases	Data awaited

Table 1 – Audit results before and after early QI intervention

Results

- Only 20 of 38 patients (53 %) had baseline haematinics; 5 were deficient, with appropriate follow-up in 2.
- 9 untested patients were later found deficient, often during routine Care & Treatment Plan reviews, with unclear testing rationale; only one was appropriately monitored.
- Monitoring responsibility was inconsistently documented. After introducing the prompt and blood-set, documentation in new cases has so far improved to 100%, with positive staff feedback on clarity of ownership.

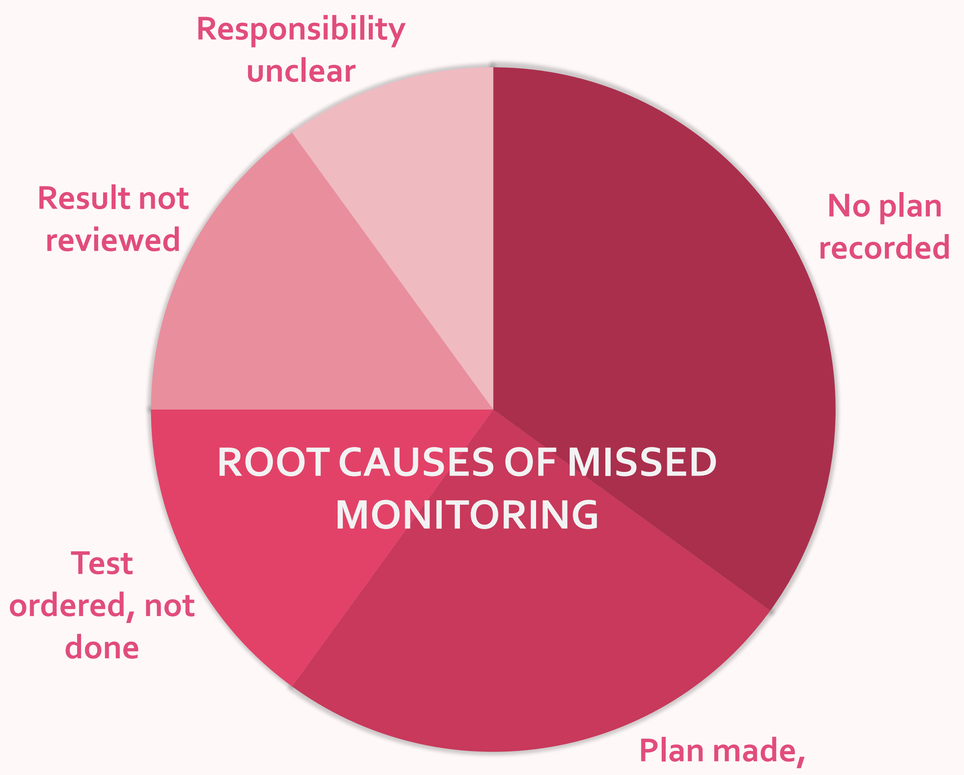

Figure 1 – Common reasons for missed or delayed haematinic monitoring (baseline sample, n=14)

Conclusions

Baseline and symptom-driven testing alone miss clinically significant deficiencies. Routine admission and annual haematinic screening, supported by clear monitoring tools, reduce repeat venepuncture and promote parity of esteem.

Next steps include embedding electronic prompts, formalising grab-sheets, pharmacy cross-checks, and re-audit at six months to assess sustainability and clinical impact.

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