Bodyscan Ltd

Bodyscan W1

Inspection report

London Medical
49 Marylebone High Street
London
W1U 5HJ
Tel: 07454791758

Date of inspection visit: 28 May 2021
Date of publication: 16/07/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This was a focused inspection to check on issues of concern from our previous inspection.

Our rating of this location improved. We rated it as good because:

- Staff now assessed patient's individual risks, acted on them and kept contemporaneous care records.
- There was a clear referral, authorisation and justification process in place. This process was followed before dual energy X-ray absorptiometry (DEXA) scans were carried out on patients.
- Compliance with governance in relation to maintaining contemporaneous patient record, obtaining consent, escalation of incidental or significant findings, use of the referrals and justification process had improved since our last inspection.

However:

- Further work was needed to ensure scan results, referral forms and patient correspondence was always accessible for all patients on the service's electronic records system.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	

Summary of findings

Contents

Summary of this inspection

Background to Bodyscan W1

Bodyscan W1 is operated by Bodyscan Limited. The service was registered with the Care Quality Commission (CQC) in January 2017 and located in Central London. The facility is operated out of one room rented from another independent health provider, also registered with CQC. The service provides a diagnostic imaging service to privately funded adults only.

The service uses a dual energy X-ray absorptiometry (DEXA) scanner to measure patient's body composition in relation to fat loss, muscle gain and sport performance. DEXA is a technique involving the use of low ionising radiation to measure body composition: precisely the proportion of fat, bone and muscle in a human body. It is also used for sports performance assessment and non-medical uses.

The location has had a registered manager in post since January 2017. The service is registered to provide the regulated activity:

- Diagnostic and screening procedures.

As of May 2021, Bodyscan W1 employed one operator, one administrative staff member and a registered manager who was the sole director of the company.

The service has been inspected once before, in February 2019. Following the February 2019 inspection, the provider was rated as requires improvement and served two requirement notices for failing to comply with Regulation 12 (safe care and treatment) and Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was the second inspection of the service. We found that significant improvements had been made and the provider was now compliant with all requirement notices served following the first inspection.

How we carried out this inspection

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

We inspected the service on 28 May 2021 using our focussed inspection methodology. We inspected the service to determine whether the provider was now compliant with the requirements set out in the Requirement Notice issued in July 2019.

During this inspection, the team visited the registered location and was on-site for half a day. During the inspection we spoke with two members of staff including the registered manager, two patients, observed two scan procedures and reviewed 10 patient records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that all patient records and correspondence are stored and available in the electronic patient record system.
- The service should consider carrying out regular patient record audits to identify any areas for improvement and good practice.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good

Diagnostic imaging

Safe	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

This inspection focused on specific areas of safe. Our rating of safe improved. We rated it as good.

Assessing and responding to patient risk

Compliance with the management of patient risk, use of the referral process and justification of scans had improved since our last inspection. Staff removed or minimised risks to patient.

The service had clear systems and processes in place for escalation of incidental or significant findings of a patient's scan result. Staff identified, and quickly acted on, risks to patients such as abnormal scan results. The operator was trained and competent in the ionising radiation (medical exposure) regulations (IR(ME)R) and interpreting of scan results. Since the last inspection, the provider had developed an escalation policy and flow chart for reporting abnormal findings. Staff we spoke with were familiar with the escalation process. We saw examples of where staff had escalated concerns or abnormal findings appropriately with the service's medical referrer, who was a general practitioner (GP) with expertise in IR(ME)R. For example, staff had liaised with the service's medical referrer about their concerns after a scan result showed an indication of a possible blood clot. The doctor confirmed the scan's findings, and the patient was advised to see their GP for further assessment and treatment.

The service had a clear referral, authorisation and justification system and process in place for which patients can be accepted for a DEXA scan. The booking and referral form include eligibility criteria and justification for which a patient could be accepted into the service for a DEXA scan. This included that a patient must be 18 years old or over, not pregnant, and had not had DEXA or other diagnostic scan in the last eight weeks. The service did not provide bone density scans or assess patient's risk of osteoporosis. Patients that wished to have a bone density scan were signposted to another clinic that provide such services. The service's medical referrer and medical physicist had contributed to developing the set criteria and justification for scans and the service's procedures to minimise risk to patient. We observed and patients told us that staff went through their referral form, consent form and asked additional questions to explore the purpose of why they were requesting a DEXA scan. This helped staff to determine if they met the referral, authorisation and justification criteria and whether there was any reason the patient should not be approved for the scan or exposed to radiation exposure. This was an improvement from the last inspection when there was no clear referral and justification process in place and is in line with best practice recommendations.

We saw evidence that all scans were medically referred, justified and signed by the medical referrer who is a registered clinician with expertise in IR(ME)R. This is in line with the service's protocol and the Ionising Radiation (Medical Exposure) Regulation 2000 and the Justification of Practices Involving Ionising Radiation Regulation 2004 (JoPIIR, 2004). These regulations require all practices involved in the deliberate exposure of persons to ionising radiation such as DEXA scan to be justified in terms of risk by a registered health professional. This was an improvement from the last inspection when not all scans were appropriately referred and authorised.

The operator was qualified under IR(ME)R to authorise the DEXA scan and ensure there had been no change in circumstance and justification for having the DEXA scan. This was in line with the Committee on Medical Aspects of Radiation in the Environment (COMARE) 2019 guidelines. Staff were trained and competent to answer patients queries in relation to the procedure, risk and result. We observed, and patients told us, that staff provided an explanation of the procedure, answered their questions and gave sufficient information to enable them to understand the scan process, risks and benefits including the possibility of incidental and abnormal findings being identified before obtaining consent and carrying out the procedure. Patients were also sent information on the low level of radiation risks via email following their booking. This was in line with national guidance on management of risks and consent. This was an improvement from the last inspection when we were not assured about the consent process, approval of scans and how patients' questions were addressed by staff before their procedures.

To mitigate the risk of individuals being exposed to cumulative radiation doses from multiple scans. It is best practice that radiation exposures should be kept as low as reasonably achievable (ALARA). The provider had a set ionising dosage for all patients, which had been agreed with their radiation protection advisor (RPA) to minimise the risk of patients being exposed to high levels of ionising radiation and reduce IR(ME)R incidents. The provider now kept adequate records of the patient doses in the patient's individual records, which is in line with best practice, their policies and procedures.

To reduce the risk of over exposure to radiation staff told us and we saw that patients were advised to have scans every 12-16 weeks. Patients were required to confirm during their booking, consent and scan appointment that they have not had DEXA or other diagnostic scan within the last eight weeks. We saw evidence in the patients' records we reviewed that returning patients did not have more than four scans a year. This was in line with national guidelines and an improvement from the last inspection when we found a lack of contemporaneous individual patients' records system to prevent frequent DEXA scanning of patients and over exposure to radiation.

The service followed the Society of Radiographers Paused and Checked guidance for patient identification check to ensure they had the right patient. Staff checked they had the right patient by confirming their name, address and date of birth. The provider used the patient's email address as the patient ID. The service did not offer DEXA scans to those under 18 years of age. Staff requested photographic ID if a patient looked below 18 years or when the information provided did not match their booking, referral or consent form. We were assured that appropriate systems were in place to check and record patient identity details on the electronic record. This was an improvement from the last inspection when the provider did not hold patient's identity information on a records system.

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care. However, scan results and referral forms were missing from some patients' records.

Individual patient's records included their name, date of birth, previous/upcoming appointments, referral forms, consent form, results of scan, any incidental findings or abnormal results were stored on the electronic patient system implemented in 2019 following the last inspection. Staff could easily access patient's information such as previous scan result, bookings and appointment history that was needed to deliver safe care, determine the justification for carrying out a DEXA scan and mitigate the risk of repeat scans being undertaken by the provider within a short period of time. This was an improvement from the last inspection, when the service did not hold patient's records in one place and staff could not access all patients record on a central record system.

Good

Diagnostic imaging

Patients were provided with printed copies of their scan results and explanatory notes in person, electronic copies of these documents were sent to them by email following their appointment. The scan results included a comparison to previous results, analysis of fat mass and lean component and a calorie target to achieve a fat-loss goal within a specified time period. However, we noted a copy of the email correspondence sent to patients with their scan result and summary explanation were not routinely stored in the individual electronic records except where there had been an incidental or significant finding and the patient had been advised to contact their GP. The registered manager told us this was because the attached documents were available in the electronic records and the purpose of email was for marketing services to patients. The registered manager stated that routine patient email correspondence should be included with patient records with a new combined patient record and booking system due to be implemented before the end of 2021. The new system for holding patient records in one place, reviewed during inspection was now fully embedded in the service.

We reviewed the records of 10 patients who had their DEXA scan between 01 March to 27 May 2021 and found all 10 records included the patient's personal details, justification for having the DEXA scans and consent forms. The patient's referral form and informed consent form were automatically uploaded to the patient record system, while the scan results report was added manually by the operator. We found two of the 10 files we reviewed did not include a scan result and a referral form. When informed of these missing documents during the inspection the registered manager stated he would report the issue to the electronic record provider and work with them to resolve the matter. The risk of failure to automatically upload documents had not been identified as the provider did not carry out routine record audits. Following our inspection, the provider told us a monthly record audit would be implemented in the service, commencing in July 2021 and their record's policy would be updated to reflect this change. The provider submitted copies of the retrieved scan result from the DEXA machine and referral form from the software cloud system which have been uploaded to the individual patient records.

Are Diagnostic imaging well-led?

Good

This inspection focused on specific areas of leadership. Our rating of well-led improved. We rated it as good.

Governance

Compliance with governance processes in relation to record keeping, consent, risk, review of policies, authorisation and escalation of incidental or significant scan result had improved since our last inspection.

Since our last inspection there had been improvements in the governance and management of risks in relation to record keeping, obtaining informed consent and prevention of patients having repeat scans within a short period. All policies and procedures we reviewed were up to date, reflected national guidance and included a review date. The provider had implemented an escalation policy and flow charts since our previous inspection. The policy set out the process staff should follow to escalate any incidental or significant findings. We saw examples of where staff had escalated incidental findings to the medical referrer to determine if further investigations were required and the patient's GP made aware. This was in line with the COMARE 2019 guidelines and an improvement from the last inspection when there was no clear escalation process on reporting incidental or significant findings and policies did not have a review date.

Managing risks, issues and performance

Good

Diagnostic imaging

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had systems and processes in place to identify, record and mitigate risks to eliminate or reduce them. The service's risk register included a description of each risk, assessment of the likelihood of the risk recurring, mitigating actions in place and when it was last reviewed. The risk register included risks such as equipment, staffing and infectious diseases and reflected possible risks that could occur in the service. This was an improvement from the last inspection when some of the risks we identified during inspection were not recorded on the risk register.