Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Focused Inspection Report: Independent Healthcare

Service: Truly Dental Glasgow, Glasgow

Service Provider: Capital Care Glasgow Limited

(previously known as EDG Restore Limited)

21 August 2026

NHS SCOTLAND

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1 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

Following our last inspection in February 2026, the provider had changed from EDG Restore Limited to Capital Care Glasgow Limited, a subsidiary of the Truly UK group. This is a dentist-owned network of practices operating in Ireland, the UK and the United Arab Emirates (UAE). The service operated within Truly UK group's corporate frameworks and policies. For the purposes of this report, we will refer to Truly when referring to the Truly UK group, and to the provider when referring to Capital Care Glasgow Limited.

Since the provider had been acquired by Truly, the service had applied to Healthcare Improvement Scotland to vary its conditions of registration to introduce sedation treatment. Following a sedation practice visit, we approved this variation in May 2026 and amended the service's conditions to allow the provision of dental treatment under conscious sedation (using drugs to reduce patient anxiety to allow treatment to take place).

We carried out an announced focused inspection to Truly Dental Glasgow on Friday 21 August 2026. The purpose of the inspection was to assess whether it was safe to allow the service to continue providing conscious sedation treatment to patients (using drugs to reduce patient anxiety to allow treatment to take place), following the provider's notification to Healthcare Improvement Scotland of a significant adverse event. We reviewed the circumstances surrounding the significant adverse event, assessed the service's sedation procedures and spoke with a number of staff during the inspection. Due to the short notice nature of this inspection, we did not seek the views of patients.

Based in Glasgow, the service is an independent clinic providing dental care.

The inspection team was made up of three inspectors.

At the end of the inspection, we were not assured that patients were being assessed for sedation treatment appropriately. Therefore, we served an Emergency Condition Notice on the provider, removing our approval for sedation treatment to be provided. We subsequently served an Improvement Notice on the provider requiring improvements in the way patients are assessed for sedation treatment.

What we found and inspection grades awarded

For Truly Dental Glasgow, the following grades have been applied.

Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Summary findings	**Grade awarded**
Staff had been trained in the duty of candour principles and the provider's duty of candour policy was published on its website. A recent patient care record audit showed that all patients had been appropriately consented for sedation and planned dental treatment. The significant adverse event and duty of candour reviews must be concluded and the outcomes shared with Healthcare Improvement Scotland. A procedure must be implemented for contacting GPs of patients identified as high risk in order to make informed clinical judgements about their treatment. An effective governance process must be implemented for ensuring that patients identified as high risk are escalated for further assessment by more senior clinical staff, where necessary. Patient care records must contain all necessary information about patients' consultations, examinations, assessments and treatment.	Unsatisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care*
Detailed sedation patient care records must be kept, including an accurate record of the teeth present in patients' mouths. Patients must have their suitability for treatment appropriately assessed and categorised, and conscious intravenous sedation must only be provided to patients that meet the appropriate assessment criteria. The time and administration doses of local anaesthetic must always be documented.	Unsatisfactory

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at:
Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Capital Care Glasgow Limited to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in eight requirements. An Improvement Notice has been served on the provider in relation to all requirements made during this inspection, requiring improvement.

Implementation and delivery	
Requirements	
1	The provider must conclude its significant adverse event review and duty of candour review of the recent serious incident involving a patient and share the outcomes of both with Healthcare Improvement Scotland. All learning identified must ensure that future sedation treatment provided by the service will be of a quality which is appropriate to meet the needs of patients (see page 12). Timescale – by 13 January 2027 *Regulation 13(2)(b)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Requirements	
2	The provider must implement a written procedure for contacting the GP of patients who are assessed as high risk for treatment and using this information to make an informed clinical judgement about whether the patient's treatment should be delayed, staged, referred or refused (see page 13). Timescale – by 13 January 2027 *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must implement an effective documented governance process for ensuring that patients initially assessed as high risk are appropriately escalated to senior clinical staff for a decision about their suitability for treatment. A record of all decision making related to patient treatment must be kept in the patient care record to ensure patients' health, welfare and safety (see page 13). Timescale – by 13 January 2027 *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
4	The provider must ensure that patient care records contain all necessary information about patients' consultations, examinations, assessments and treatment (see page 14). Timescale – by 13 January 2027 *Regulation 4(2)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
None	

Results

Requirements

5 The provider must ensure that conscious intravenous sedation is only provided to patients that meet the appropriate assessment criteria. Patients with a classification of American Society of Anesthesiologists (ASA) 3 (severe systemic disease) or higher must not be treated in this service (see page 16).

Timescale – by 13 January 2027

Regulation 3(a)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

6 The provider must ensure that patient care records contain an accurate record of the teeth present in patients' mouths (see page 16).

Timescale – by 13 January 2027

Regulation 4(2)(a)(b)(c)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

7 The provider must ensure that appropriate sedation monitoring details are recorded during patient sedation treatment so that the safe management of patients can be demonstrated (see page 16).

Timescale – by 13 January 2027

Regulation 4(2)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

8 The provider must ensure that the time and administration doses of local anaesthetic are always documented to ensure maximum doses are not exceeded (see page 16).

Timescale – by 13 January 2027

Regulation 4(2)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Recommendations

None

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website:
Find an independent healthcare provider or service – Healthcare Improvement Scotland

Capital Care Glasgow Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Truly Dental Glasgow for their assistance during the inspection.

2 What we found during our inspection

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Staff had been trained in the duty of candour principles and the provider's duty of candour policy was published on its website. A recent patient care record audit showed that all patients had been appropriately consented for sedation and planned dental treatment.

The significant adverse event and duty of candour reviews must be concluded and the outcomes shared with Healthcare Improvement Scotland. A procedure must be implemented for contacting GPs of patients identified as high risk in order to make informed clinical judgements about their treatment. An effective governance process must be implemented for ensuring that patients identified as high risk are escalated for further assessment by more senior clinical staff, where necessary. Patient care records must contain all necessary information about patients' consultations, examinations, assessments and treatment.

Quality improvement

A small team of dentists, dental nurses, a patient co-ordinator and a receptionist continued to work in the service, and the lead dentist remained the appointed registered service manager with Healthcare Improvement Scotland. They took most of the responsibility for the day-to-day running of the service, with support from Truly's head of operations (UK) and the clinical director of global operations.

Following a recent serious incident involving a patient, the provider had initiated a significant adverse event review to establish any learning that could be taken forward. The outcomes of significant adverse event reviews carried out by services must be shared with Healthcare Improvement Scotland.

The provider had also triggered its duty of candour obligation (where healthcare organisations have a statutory responsibility to be honest with patients when something goes wrong). As required, the provider was now in the process of also carrying out a duty of candour review of this same incident as part of its

duty of candour obligation. The outcomes of duty of candour reviews must also be shared with Healthcare Improvement Scotland.

Staff had been trained in the duty of candour principles and the provider's duty of candour policy was published on its website.

What needs to improve

While we saw initial drafts of the reports from both the significant adverse event review and the duty of candour review, neither had yet been concluded. The final reports must be shared with Healthcare Improvement Scotland within a reasonable timeframe (requirement 1).

There was no formal procedure for contacting a patient's GP to seek clarity on their medical history and, therefore, their suitability for planned treatment, either where their initial assessment indicated a high risk for treatment or their observations at assessment were outwith normal limits. There was also no process for considering staging or delaying treatment or referring the patient to a more experienced team for further medical assessment and to decide on the best patient-centred treatment option (requirement 2).

Staff told us they sought a second opinion on patients' suitability for treatment from Truly's clinical leadership team, where appropriate. However, there was no formalised process for demonstrating this took place. While staff described a recent example of a dentist seeking a second opinion, there was no record that this had taken place or what the agreed outcome was. From a patient care record we reviewed of a patient who had received sedation treatment, we saw that the patient's treatment had gone ahead despite their high-risk status and we found a lack of clarity about the escalated consultation with the Truly's clinical leadership team. Evidence of clinical consultations must be documented in patient care records, along with a record of the decision to proceed, delay or refuse treatment (requirement 3).

Requirement 1 – Timescale: by 13 January 2027

- The provider must conclude its significant adverse event review and duty of candour review of the recent serious incident involving a patient and share the outcomes of both with Healthcare Improvement Scotland. All learning identified must ensure that future sedation treatment provided by the service will be of a quality which is appropriate to meet the needs of patients.

Requirement 2 – Timescale: by 13 January 2027

- The provider must implement a written procedure for contacting the GP of patients who are assessed as high risk for treatment and using this information to make an informed clinical judgement about whether the patient's treatment should be delayed, staged, referred or refused.

Requirement 3 – Timescale: by 13 January 2027

- The provider must implement an effective documented governance process for ensuring that patients initially assessed as high risk are appropriately escalated to senior clinical staff for a decision about their suitability for treatment. A record of all decision making related to patient treatment must be kept in the patient care record to ensure patients' health, welfare and safety.

- No recommendations.

Planning for quality

We reviewed a patient care record audit which the service had recently carried out. This showed that all patients had been appropriately consented for sedation and planned dental treatment. We saw that the outcome of the audit had been circulated to staff.

We also saw that changes had recently been made to the service's standard template forms to ensure better compliance going forward. This included a new patient assessment template that had been drafted since the recent significant adverse event. This new template included clearer guidance for staff about the potential alerts to be aware of when assessing patients for treatment and when it was appropriate to seek advice or a second opinion.

What needs to improve

We reviewed a sedation audit which the service had recently carried out. Although the service had appropriate standard template forms available to support the recording of patient information, the audit had identified a number of significant gaps in record keeping that required immediate action. These included:

- 10% of patients had no clinical baseline observations recorded such as breathing rates and oxygen levels
- 30% of patients had no body mass index recorded

- 30% of patients had no American Society of Anesthesiologists (ASA) classification recorded (a grading system to determine the health of a person before a surgical procedure that requires sedation), and
- 70% of patients had no recovery time information recorded.

It is important that all necessary information relating to a patient's consultation, examination, assessment and treatment is documented to support the safe delivery of care and treatment.

These audit findings demonstrated that key information was not being recorded consistently in the sedation patient care records. At the time of the inspection, no action plan had been developed as a result of this audit to ensure that appropriate actions would be taken forward to address these gaps in record keeping (requirement 4).

Requirement 4 – Timescale: by 13 January 2027

- The provider must ensure that patient care records contain all necessary information about patients' consultations, examinations, assessments and treatment.

- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

Detailed sedation patient care records must be kept, including an accurate record of the teeth present in patients' mouths. Patients must have their suitability for treatment appropriately assessed and categorised, and conscious intravenous sedation must only be provided to patients that meet the appropriate assessment criteria. The time and administration doses of local anaesthetic must always be documented.

The operating team that provided sedation treatment was made up of two dentists, with one administering the sedation medication and carrying out the dental treatment, and the other assisting and monitoring sedation. A dental nurse was also available on site if needed. All clinicians undertaking sedation treatment had been appropriately trained and certified.

We reviewed a number of sedation patient care records and found that the level of detail recorded was generally good. Artificial intelligence (AI) software was being used to collate and transcribe the key elements of care provided. Patient cases often lasted a number of hours and it was clear that patients were not receiving more sedation drugs than necessary over the course of their treatment.

What needs to improve

From the sedation records we reviewed, we found that patients were not being appropriately assessed and categorised for sedation treatment, according to the American Society of Anesthesiologists (ASA) physical classification system. For example, one patient, whose assessment record showed a complex medical history and a range of health conditions for which they were taking multiple prescription medications, had been incorrectly assessed and categorised as ASA 2 (patients with mild systemic disease) when they were actually ASA 3 (patients with severe systemic disease). This meant that the patient should not have been treated under sedation (requirement 5).

While the detail recorded in patient care records was generally good, we found that the record of teeth present in a patient's mouth was not always recorded accurately (requirement 6).

When reviewing patient sedation monitoring records, we found that one patient's observations were significantly outwith normal limits at the start of intravenous sedation treatment and remained so throughout the procedure. The sedation monitoring record did not clearly document the times at which patient clinical observations such as breathing rates and oxygen levels were recorded. This meant that it could not be clearly evidenced that the patient's condition had been appropriately monitored and assessed during treatment (requirement 7).

The staggered dosage levels and timings for administering local anaesthetic to patients over the course of their treatment was not always documented. This would ensure that maximum dosages are not exceeded (requirement 8).

Requirement 5 – Timescale: by 13 January 2027

- The provider must ensure that conscious intravenous sedation is only provided to patients that meet the appropriate assessment criteria. Patients with a classification of American Society of Anesthesiologists (ASA) 3 (severe systemic disease) or higher must not be treated in this service.

Requirement 6 – Timescale: by 13 January 2027

- The provider must ensure that patient care records contain an accurate record of the teeth present in patients' mouths.

Requirement 7 – Timescale: by 13 January 2027

- The provider must ensure that appropriate sedation monitoring details are recorded during patient sedation treatment so that the safe management of patients can be demonstrated.

Requirement 8 – Timescale: by 13 January 2027

- The provider must ensure that the time and administration doses of local anaesthetic are always documented to ensure maximum doses are not exceeded.

- No recommendations.

Appendix 1 – About our inspections

Our quality of care approach and the quality assurance framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.



Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.



During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.



After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
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