Mr. Shahram Erfanmanesh

Farlington Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 March 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Background

Farlington Dental Practice is a dental practice providing private treatment for both adults and children.

The practice is situated in a converted domestic dwelling situated north of Portsmouth, Hampshire. The practice has two dental treatment rooms and a separate decontamination room used for cleaning, sterilising and packing dental instruments.

The practice employs a dentist, hygienist, dental nurse, receptionist and a practice manager. The practice's opening hours are Monday and Wednesday 9am to 5.30pm, Tuesday 2pm to 7pm and Thursday and Friday 9am to 1pm. There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed.

Mr. Shahram Erfanmanesh is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

During our inspection we reviewed 12 CQC comment cards completed by patients and obtained the view of 12 patients on the day of our inspection

Summary of findings

We carried out an announced comprehensive inspection on 7 March 2016 as part of our planned inspection of all dental practices. Our inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- The practice philosophy was to provide high quality patient centred care with an emphasis on the prevention of dental disease at all times
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice manager acted as the safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- A system was in place to report incidents with practice meetings used as a vehicle for shared learning.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence guidelines
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff recruitment files contained essential information in relation to Regulation 19, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015.
- Staff received training appropriate to their roles and were supported in their continuing professional development.
- Staff we spoke to felt well supported by the practice owner and were committed to providing a quality service to their patients.
- Information from 12 completed Care Quality Commission comment cards gave us a completely positive picture of a friendly, caring, professional and high quality service.
- The practice received no complaints throughout 2015

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?
We found that this practice was providing effective care in accordance with the relevant regulations.

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

Are services caring?
We found that this practice was providing caring services in accordance with the relevant regulations.

We collected 12 completed Care Quality Commission patient comment cards and obtained the views of a further 12 patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?
We found that this practice was providing responsive care in accordance with the relevant regulations.

The service was aware of the needs of the local population and took these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services when required. The practice had a ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?
We found that this practice was providing well-led care in accordance with the relevant regulations.

The principal dentist, practice manager and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the principal dentist and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Farlington Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 7 March 2016. The inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff recruitment records. We spoke with six members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records. We reviewed 12 CQC comment cards completed by patients and obtained the view of 12 patients on the day of our inspection. Patients gave positive feedback about their experience at the practice.

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To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there were no incidents during 2015 that required investigation. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. Where relevant these incidents were sent to all members of staff by the practice manager. The practice manager explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred every four to six weeks.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentist was responsible for ensuring safe recapping using specialised needle guards. This is a recognised method used in dentistry for the recapping of used needles. The dentist was responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the principal dentist how they treated the instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam (a rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice manager acted as the safeguarding lead and as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator, a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies.

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

Are services safe?

We looked at three staff recruitment files and records confirmed all had been recruited in accordance with the practice's recruitment policy. Staff recruitment records were ordered and stored securely.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments and included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice.

Risk assessments had been reviewed on a regular basis. The practice had a current business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

All of the patients we asked said they felt the practice was clean and hygienic. There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed and the practice. This was demonstrated through direct observation of the cleaning process and a review of practice protocols that showed HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We observed that audits of infection control processes carried out in March 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the two dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed for clinical staff. The drawers of treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. This included the working surfaces, dental unit and dental chair. They also explained how the dental unit water lines were maintained. The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in June 2015. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument re-processing. The dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process. Following inspection with an illuminated magnifier instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilised, they were pouched and stored until required. Pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. We observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate storage container adjacent to the practice prior to collection. Waste consignment notices were available for inspection.

Are services safe?

Patients' could be assured that they were protected from the risk of infection from contaminated dental waste. General environmental cleaning was carried out by an external cleaner and they carried out cleaning according to a cleaning plan developed by the practice.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in October 2015 and a Pressure Vessel Certificate had been issued for the dental compressor in August 2015. The practice X-ray machine had been serviced and calibrated in January 2016. Electrical testing had been carried out in October 2015 and the gas boiler had been serviced in March 2016.The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination pack for the X-ray set along with the three yearly maintenance, a copy of the local rules and notification to the Health and Safety Executive that radiation was being used at the location. The maintenance log was within the current recommended interval of three years.

A radiological audit had been carried out in between January and March 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that confirmed appropriate staff had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records seen showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE is a simple and rapid screening tool that is used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

The dental hygienist we spoke with explained how they worked together with the dentists to improve the outcomes for patients. They worked within their scope of practice to prescriptions provided by the dentist which included the treatment of patients suffering from moderate to severe forms of gum disease. All of the dental care records we saw were detailed, accurate and fit for purpose.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentist in delivering preventative dental care. The dental hygienist we spoke with explained how they contributed to the prevention agenda. This included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We asked 12 patients if they felt there was enough staff working at the practice. Of these 11 said they did and one was not sure. Staff told us the staffing levels were suitable for the size of the service. We observed a friendly atmosphere at the practice. All the staff we spoke with told us they felt supported by the dentist and by the practice manager. They told us they felt they were encouraged to progress.

The practice employed a dentist who was supported by three dental nurses of whom one was on probation prior to starting training, one receptionist and a practice manager. However we did note that the dental hygienist was working without chairside support. We drew to the attention of the practice manager the advice given in the General Dental Council's Standards for the Dental Team about dental staff being supported by an appropriately trained member of the dental team at all times when treating patients in a dental setting.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time. The practice maintained a log of the referrals made so that they could monitor the progress of each referral and keep the patient informed in a timely way.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The dentist we spoke with had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients. They explained that they would not normally provide treatment to patients on the first appointment unless they were in pain or their presenting condition dictated otherwise. The dentist felt that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan. We reviewed a number of records which confirmed this approach had taken place. To assist in the consent process, the dentist used a special camera to take photographs of the teeth prior, during and at the end of dental treatment. This included the condition of teeth requiring treatment, the appearance of the gums and of soft tissue. These provided a means of patient education as well as preventing medico-legal problems in cases where patients could dispute the dentist's findings and treatment outcomes.

The dentist explained how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We asked 12 patients if the dentist treated them with care and concern. Of these 11 said they did and one did not have an opinion either way. All the patients we asked said they had confidence and trust in the dentist.

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinet in a room off the waiting area. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 12 completed CQC patient comment cards and obtained the views of nine patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area being polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

All the patients we asked said the dentist was good at involving them in decisions about their care and treatment. The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. Booklets were also available in the waiting area and on the practice website that detailed the costs of private treatment. The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. The practice waiting area displayed a variety of information including the practice patient information leaflet. This explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. We observed that the appointment diaries were not overbooked and this provided capacity each day for patients with dental pain to be fitted into urgent slots. The dentist decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice building was spacious and fully accessible to wheelchair users, prams and patients with limited mobility. The reception desk was low which accommodated wheelchair users without them needing to move to a separate area.

Treatment rooms were large and accessible to patients who could transfer from wheelchairs. Telephone interpreter services were also available for patients whose first language was not English. One surgery was set up to treat patients in their own wheelchair who could not, or did not wish to, transfer to a dental chair.

Access to the service

Appointments were available on Monday and Wednesday 9am to 5.30pm, Tuesday 2pm to 7pm and Thursday and Friday 9am to 1pm. Appointments could be made in person, by telephone or on-line via the practice website. All the patients we asked said they were satisfied with the practice opening hours.

Staff told us patients were seen as soon as possible for urgent care during practice opening hours and this was normally within 24 hours. Appointments were available each day to accommodate this. Patients told us and comment cards reflected that they felt they had good access to routine and urgent dental care.

There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring depending on their symptoms.

Concerns & complaints

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

The practice manager was the designated lead for the handling of complaints. Staff we spoke with were aware of the procedure to follow if they received a complaint and forms were available for recording complaint information. For example, a complaint would be acknowledged within three working days and a full response would be provided to the patient within ten working days. We were told no complaints had been received in the previous 12 months of our inspection.

Patient information about how to make a complaint was visible in the practice. We asked 12 patients if they knew how to make a complaint if they had an issue and six said yes, three weren't sure and three patients told us they wouldn't know.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of the principal dentist and the practice manager who were responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice manager on a regular basis.

Leadership, openness and transparency

The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the principal dentist. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the principal dentist and practice manager were proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. These included infection control and X-ray quality. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example infection control audits were undertaken every six months and X-ray audits were carried out in accordance with current guidelines.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training was completed through a variety of resources including online courses. Staff were given time to undertake training which would increase their knowledge of their role.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient feedback forms in the waiting area, compliments and complaints. Changes made as a result of this feedback included extending surgery times on a Tuesday evening.

All of the staff told us they felt included in the running of the practice and how the dentists and practice manager listened to their opinions and respected their knowledge and input at meetings. Staff told us they felt valued and were proud to be part of the team.