ORGANISATIONAL DOCUMENT AND GENERAL SERVICE CHARTER



Città Solidale
Cooperativa Sociale
Latiano (BR)

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INTRODUCTION

With this document we aim to guarantee the transparency of our Organisation. It provides an insight into our Organisation, the services we deliver, our objectives, and the monitoring methods adopted to ensure the highest quality of care and of community life.

The Organisational Document and General Service Charter should not be regarded as an information leaflet, but rather as a transparency tool protecting the right of the Guests of the facility to an optimal social, cultural and physical life, naturally in proportion to their age, their state of health and their specific needs, with a view to achieving the best possible Quality of life.

The Organisational Document and General Service Charter is a pact/contract between our Organisation and the Guest, aimed at providing an ideal response to each of their needs and, at the same time, it is intended to serve as a stimulus for improving the quality and quantity of the services offered.

This document may also be understood as a Charter of Guests' Rights. It follows from this that Guests and their families are able to monitor the services provided and to contribute to improving them through suggestions or any complaints, which will be carefully considered for the benefit of the quality of our work.

A copy of the Organisational Document and General Service Charter will be made available to anyone interested in using the services, so that they may access them with greater awareness.

Aware of the criminal penalties for false declarations and for the creation or use of false documents, as referred to in art. 76 of D.P.R. 445/2000, the undersigned Roberto Longo, born in Latiano on 06.11.1962, in his capacity as Legal Representative of the Social Cooperative Città Solidale, declares that the foregoing is true. Pursuant to Law 196/03 and GDPR 2016/679, it is further declared that the personal data collected will be processed, including by electronic means, exclusively within the scope of the procedure for which this document is issued.

The Chairman

Dr. Roberto Longo

GUIDELINES FOR THE DRAFTING AND DISTRIBUTION OF THE ORGANISATIONAL DOCUMENT AND SERVICE CHARTER

Decree-Law no. 163 of 12 May 1995, converted into Law no. 273 of 11 July 1995, requires all providers of public services, including those operating under a concession or by agreement, to adopt their own "Service Charters". R.R. no. 3/2010 of the Puglia Region requires an organisational document “setting out the general internal organisation, for each facility and functional unit”.

The Organisational Document and General Service Charter has not been written once and for all. It is subject to periodic review in order to update the information it contains and to progressively improve the standards of service quality.

The promised standards are reviewed annually.

In carrying out its activities, the Cooperative operates a Quality system in accordance with the UNI EN ISO 9001:2015 standard.

The formal adoption of the Document takes place within the Cooperative’s internal regulations and is therefore the responsibility of the management body. Nevertheless, the importance of involving staff, Guests and families in defining the commitments set out in the Charter must not be underestimated.

The Organisational Document and General Service Charter is subject to controlled distribution; the Cooperative is responsible for always providing an up-to-date copy to those concerned.

Particular care is taken in disseminating the Document both among staff, who must be aware of its contents, and among the public and all the relevant public institutions in the area, trade unions, and voluntary and citizens’ rights organisations.

PREAMBLE

Città Solidale is a social cooperative, formally established in 2000, but its roots go back to the 1980s when, in Latiano, in the province of Brindisi, a group of over 70 young people decided to embark on this adventure, founding the parent cooperative, “Integrazione sociale e lavoro” (Social Integration and Work), with a clear objective: to raise public awareness of the rights of people with mental and physical disabilities, fighting all forms of discrimination and helping them not only with care services but, above all, with therapeutic and rehabilitation pathways aimed at full social and occupational inclusion. Since then, many initiatives and numerous projects have been launched, always focused on research and innovation, to the point of becoming a model even beyond national borders, in countries such as Argentina and China.

Città Solidale is a Social Cooperative which, pursuant to art. 1 of Law 381/91, pursues the general interest of the community through the provision of quality services aimed at ensuring psycho-physical health and social and occupational reintegration for people with psychological and mental disorders, and care and a dignified life for the elderly women and men in its care.

The daily commitment to the best possible quality of life for these people, to protecting their rights, to inclusion and to combating stigma from the outside world, is carried forward with admirable enthusiasm and dedication by the health and social care workers.

Città Solidale, established in 2000, has consolidated its experience and today manages the following facilities:

- Psychiatric Residential Care Community (C.R.A.P.) “Villa del Sole”
- Psychiatric Residential Care Community (C.R.A.P.) “Villa Carlo Alberto Dalla Chiesa”
- Psychiatric Group Home “Casa Lilla”
- “Casa per la Vita” (Home for Life) “Giovanni Falcone”, low care intensity
- “Casa per la Vita” (Home for Life) “Franco Basaglia”, medium care intensity
- Healthcare Residential Facility for People with Disabilities (R.S.A. disabili) “Myosotis”
- Socio-educational and Rehabilitation Day Centre “Myosotis”
- Healthcare Residential Facility for the Elderly (R.S.A. anziani) “Rosa Aluisio”

MISSION

The fundamental principles of the Social Cooperative “Città Solidale” are:

- the promotion of the social economy, that is, an economy founded on justice and solidarity, to meet the needs of the individual;
- democratic and participatory management by its members, including in the economic sphere, through the planning of objectives and the assessment of results;
- equality among members: all members have the same rights and the same duties and work to achieve the same objectives. They oversee the life of the company and bear witness to the vitality of the enterprise;
- a local focus, in the sense that it is an enterprise of its own territory, fostering its development by championing the centrality of the person, relationships, solidarity, knowledge and loyalty, and the inclusion of vulnerable people;
- specialisation, through the study and in-depth examination of the issues dealt with in its work, the refinement of methodologies and the updating of operational tools;
- management transparency, through the active participation of all members in the life of the organisation and the external publication of the social outcomes achieved;
- the social optimisation of resources, aimed at the development of the organisation, the good of the community and effectiveness;
- the efficiency of the services provided to the people in its care;
- the development of the principle of subsidiarity, which promotes citizens’ self-organisation.

Inspired by its mission, the Cooperative has defined fundamental principles to be pursued in the delivery of its services, on which its relations with its users are based.

Its core **values** are:

- the centrality of the person and of their specific needs;
- intellectual honesty, transparency and attention to others, especially those in difficulty, these being indispensable conditions for rehabilitation, assistance and care work;
- self-responsibility, equality and fairness, without any discrimination on the grounds of gender, race, religion or political views;

- solidarity, aimed at the promotion, support and inclusion of marginalised people;
- ethical action and social responsibility, as a daily commitment to the psycho-physical well-being of the person in care;
- the attitude and conduct of staff guided by criteria of impartiality and objectivity;
- participation in the social and cultural growth of the City;
- the involvement of Guests and their families in the planning and review of the care pathway;
- continuity of care for Guests and information on the choices and therapeutic treatments proposed;
- the network of values set out in the Articles of Association, the Regulations and the Social Contract;
- effectiveness and efficiency, assessed through the level of satisfaction of Guests and their families;
- social entrepreneurship, understood as economic action aimed at generating social returns and the well-being of the individual and of the surrounding community.

AIMS

- To give concrete effect to the principles of dignity and equality of People with persistent and complex disorders, on an equal footing with all other citizens, guaranteeing them the exercise of their individual and citizenship rights;

- To guarantee elderly people in need high-quality care and assistance, loving relationships and a comfortable life;

- To ensure that People in need keep their family and social relationships and cultural interests alive;

- To combat stigma in the various forms in which it manifests itself and the exclusion of People with difficulties;

- To help people with mental disabilities recover the skills and abilities lost because of their disorder, or never acquired, so as to enable them to function fully in society and, where they so wish, in the world of work, guaranteeing personalised “recovery-oriented” care in relation to each person’s needs, within a methodology in which rehabilitation is an essential component of the care pathway.

ADMISSION AND DISCHARGE PROCEDURES

Admission procedures

Access procedures vary according to the intervention required.

Placement in the Communities takes place on the proposal of the patient's CSM/DSM/DSS, or by order of the Judicial Authority, subject to the patient being taken into care by the Local Health Authority (Azienda Sanitaria Locale).

Placement in a Community is generally arranged for an appropriate period of time.

On admission, users must bring their personal documents (identity card, tax code) and health documents (health insurance card, disability certification).

Once taken into care by the facility, the user signs a therapeutic contract through which they are informed of the content of the Therapeutic Programme (PTR/PAI) and the Internal Regulations, and receive a copy of the Service Charter.

Discharge procedures

The reason for discharge will be duly justified and reported by the team and approved by the Community Coordinator.

The user will be discharged: at their own request and with the authorisation of the referring CSM/DSM/DSS or of the Judicial Authority, on completion of their sentence or upon transfer to another Facility (REMS, Prison, …).

Discharge by the team may be decided for the following reasons:

- Lack of respect towards the community staff and/or other users; physical violence or intimidation; any theft from other users.
- Bringing in, distributing or inducing other users to consume any type of narcotic, psychotropic or alcoholic substance within the community or outside it.
- Refusal to undergo laboratory tests for narcotic substances or alcohol when the therapeutic team deems it appropriate.
- Possession of any type of weapon.
- Failure to make the payments and cover the expenses agreed upon admission.

RIGHTS AND DUTIES OF GUESTS

Direct participation in the fulfilment of certain duties is the basis for fully enjoying one's rights. Fulfilling a duty also means adhering to the therapeutic pathway and contributing to its success.

Rights

- Respect for and protection of each person's confidentiality and privacy are guaranteed in accordance with the provisions of law (D.Lgs. 196/2003 and the European Regulation GDPR 679/2016).
- To be assisted and cared for with consideration and attention, with respect for human dignity and without prejudice as to race, nationality, faith, political affiliation, sexual preferences, criminal record or social background.
- To obtain information on the services provided, the access procedures and the relevant responsibilities, as well as complete and comprehensible information about the diagnosis, the proposed therapy and the related prognosis, and the possible side effects and risks arising from the treatment, from the time of admission until discharge.
- To give genuinely informed consent before undergoing therapies and interventions; if the person is legally incapacitated, those exercising guardianship may do so on their behalf.
- To play a leading role in defining their own rehabilitation pathway and to be informed of the methodology of the care and rehabilitation pathway.
- To be properly informed of the internal regulations in force, of the sanctions and of any changes to them.
- To have data relating to their illness and any other circumstances kept confidential and to be able to have them rectified or erased.
- To have accommodation that complies with the regulations in force on prevention and safety.
- To be able to communicate with family and friends, except during periods in which this is

prohibited as set out in the therapeutic programme documentation.

- To make complaints and suggestions, which must be promptly examined, and to be informed without delay of their outcome.
- To stop taking part in the Programme whenever they see fit, on their own responsibility and by signing the voluntary discharge form.
- To be guided, at the end of the therapeutic programme, towards possible forms of social support with a view to continuity of care.

Duties

- To respect the rules, timetables, activities and everything provided for in the treatment programme.
- To take their medication regularly and undergo laboratory tests and instrumental examinations, as well as specific tests for psychotropic substances or alcohol when the therapeutic team deems it appropriate.
- Not to bring in, consume and/or induce others to consume any type of narcotic substance, alcohol or medicines not prescribed by a doctor, either inside or outside the community. Breach of this rule entails criminal consequences.
- To treat the facility's staff, other users and family members with respect; any physical violence or intimidation is prohibited, as is the taking of anyone else's property. Should this obligation not be respected, the team will be obliged to report such events to the competent authorities. Vulgar and offensive language, insults and blasphemy will likewise not be tolerated.
- Bearing in mind that they are part of a community, Guests should avoid any behaviour that may cause disturbance or discomfort to other Guests.
- To respect other Guests' rest, both during the day and at night.
- To take care of the community's equipment. Anyone who damages community property will

be required to pay compensation for the damage.

- To make the payments and cover the expenses agreed upon admission. Each user must have a cash fund available for personal expenses. The community cannot undertake to advance any sum for personal expenses.
- To ask the therapeutic team for permission for visits or outings.
- To respect the access restrictions on all rooms reserved exclusively for the therapeutic team.
- To respect the organisation and timetables of the facility at all times, on the part of both the Guest and their family members.
- Family members, friends and other persons must comply with the Community's visiting hours.
- To submit incoming mail and items to checks by staff, in order to prevent the introduction of narcotic substances and objects that might interfere with the rehabilitation pathway.
- To attend to personal hygiene daily, complying with health and hygiene rules and also helping with the cleaning of the facility.
- Not to negatively influence or incite other users to abandon the therapeutic programme.
- Not to possess any type of weapon of any size.
- To respect the ban on smoking indoors, using the designated areas.
- To accept any transfer to another community facility for therapeutic reasons.
- To inform the therapeutic team of a decision to leave voluntarily, by signing the relevant form.
- Staff, within the scope of their responsibilities, are requested to enforce the rules set out above for the smooth progress of the pathway and the well-being of the Guest.

GUEST SATISFACTION

In providing its services, the Cooperative guarantees compliance with the fundamental principles set out in the Directive of the Council of Ministers of 27/01/94 and in the Regulation on the rights and duties of the sick guest (D.P.C.M. 19/05/95). The Gelli law, also known as "Law no. 189 of 8 November 2012 - Provisions on social and healthcare facilities, implementing article 1, paragraph 67, of Law no. 190 of 6 November 2012", is an Italian law regulating social and healthcare facilities. The aim of this law is to promote the improvement of the quality of the services provided in such facilities, guaranteeing adequate standards of care and protection of patients' rights. In particular, it governs RSAs (Residenze Sanitarie Assistenziali – Healthcare Residential Facilities), residential facilities for the elderly and people with disabilities, home care services and other types of social and healthcare facilities.

The Gelli law contains provisions on the quality of healthcare services, the accreditation procedures for facilities, transparency regarding costs and the services offered, as well as procedures for the monitoring and inspection of facilities. In addition, the law establishes the rights of patients and their families, guaranteeing respect for their dignity and privacy and their participation in decisions concerning their care.

In accordance with these directives, the team guarantees the quality of the services provided and pays close attention to protecting the rights of the guest.

Furthermore, the cooperative has adopted the updates contained in Legislative Decree 62/2024.

All documentation relating to guests' data and their therapeutic rehabilitation pathway is managed in accordance with current legislation. Medical records are kept in locked filing cabinets in dedicated offices and in archives, access to which is restricted to staff, or in electronic archives protected in accordance with the latest directives (NIS2).

Guests, their family members, representatives of advocacy and voluntary associations and any interested party may make suggestions and/or lodge a complaint following any service failure, act or behaviour that has denied or limited access to the services.

Management is keen to know the opinion of guests and their families on the services and care provided. Their feedback is very useful for understanding what the problems are and identifying the most appropriate solutions to improve the effectiveness, efficiency and quality of the services offered.

Guests can submit any complaints, suggestions and proposals using a dedicated form available at the facility.

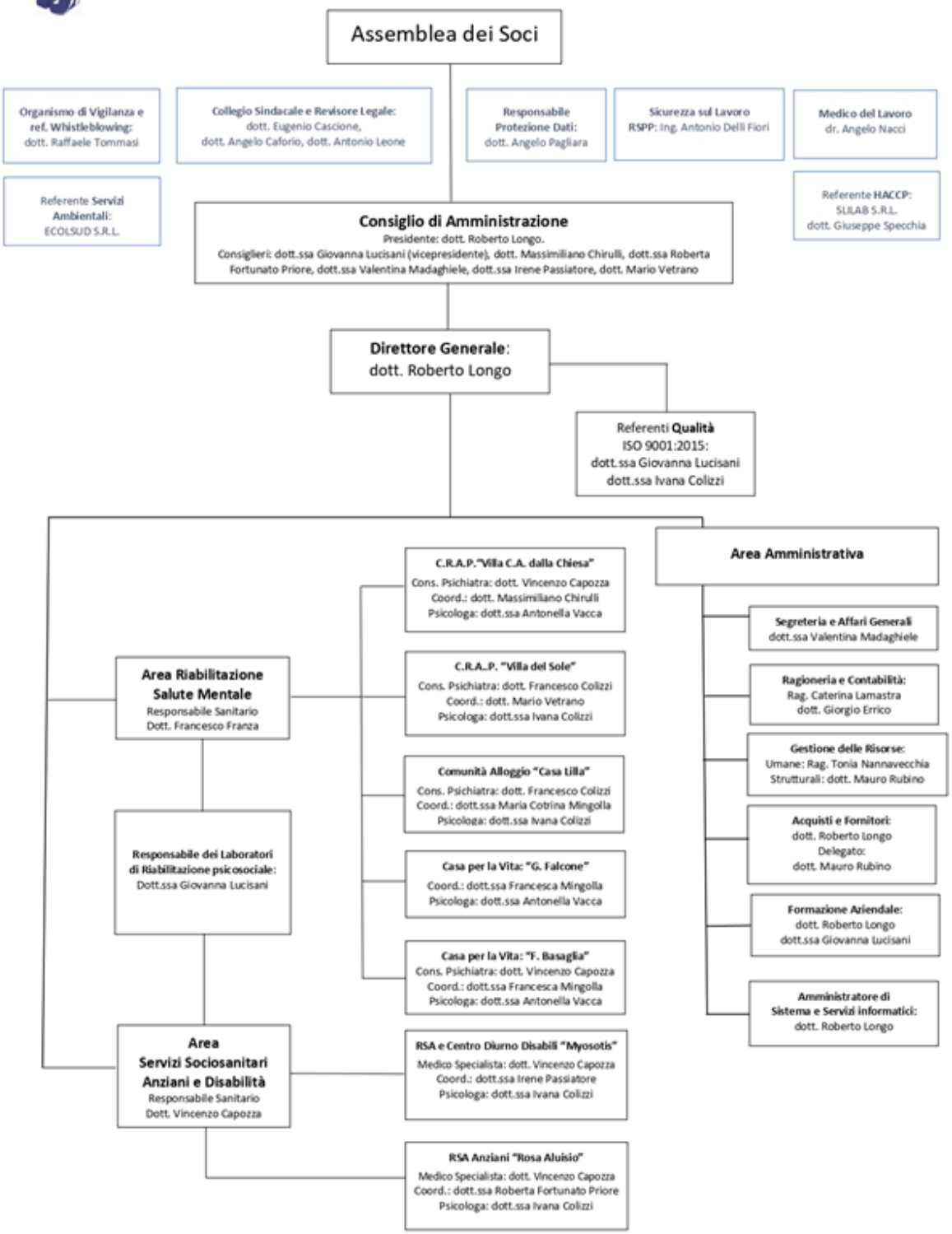
Guests may express their satisfaction with the quality of the service and care received by completing a dedicated questionnaire, which will be assessed periodically by the Organisation in order to make any improvements.

Suggestions and complaints may be submitted in various ways (Contacts on p.17); in addition, a dedicated suggestions and complaints box is provided in the Administrative Offices and in the Local Units.

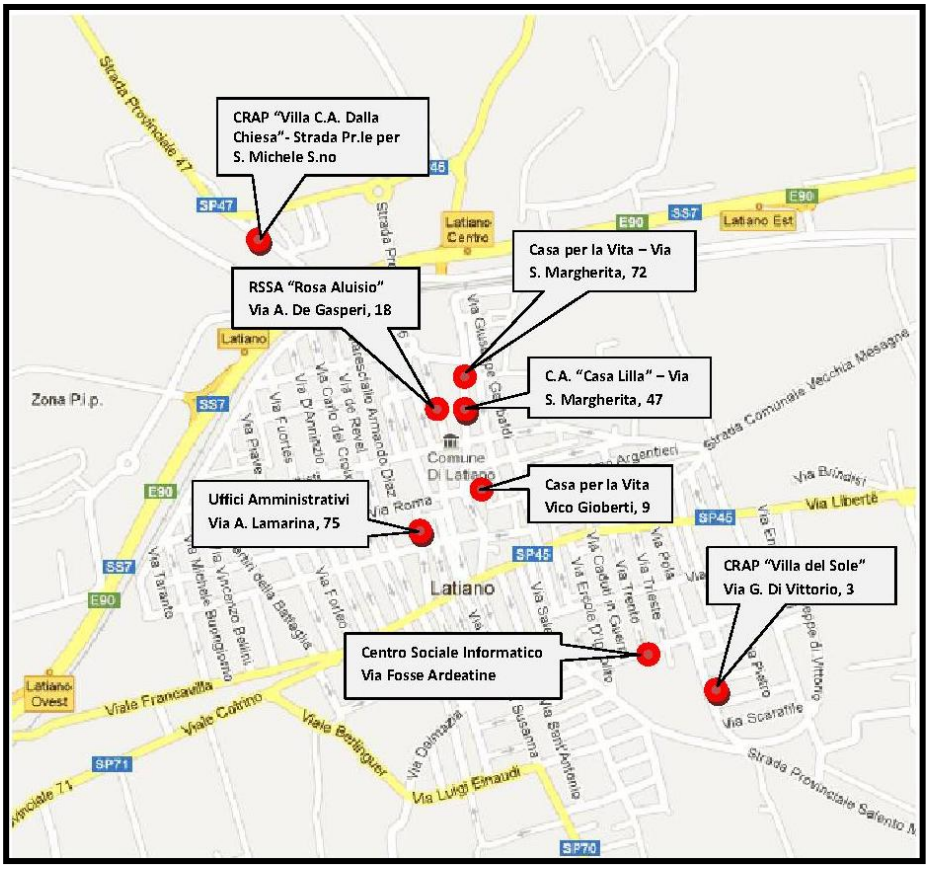
The Chairman and the Board of Directors are also available to receive reports and complaints made verbally. Once the complaint has been considered and analysed, the person concerned will be informed of the outcome of their complaint as quickly as possible and, in any case, within the time limits laid down by law.

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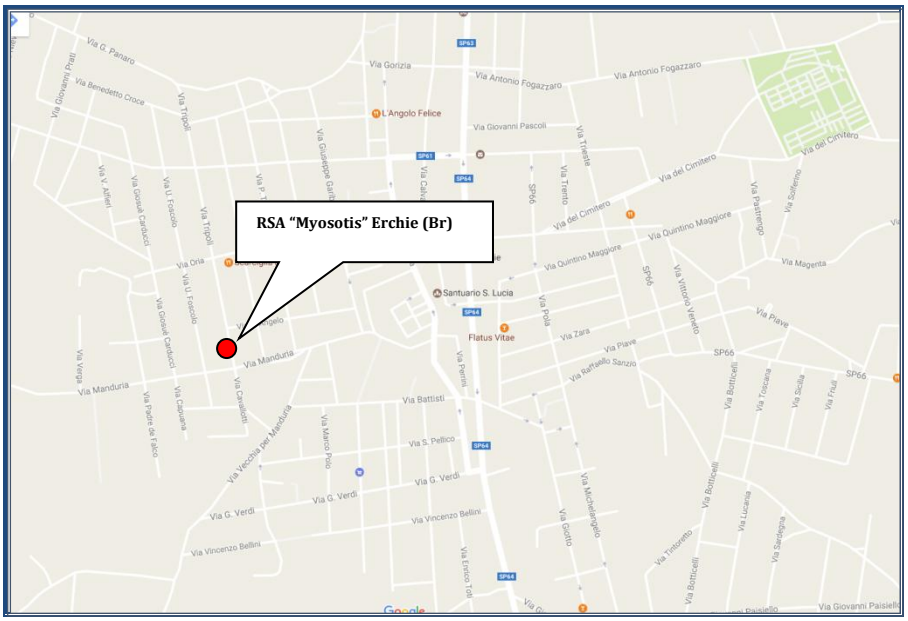
ORGANIGRAMMA DELLA COOPERATIVA SOCIALE "CITTÀ SOLIDALE"



OPERATING SITES



Map of Latiano



Map of Erchie

CONTACTS

ADMINISTRATIVE OFFICE

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DR. ROBERTO LONGO
presidente@citttasolidale.net

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PURCHASING AND CASH OFFICE
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COORDINATION OF THE REHABILITATION WORKSHOPS
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e-mail laboratori@citttasolidale.net
Telephone: 3343575378

OPENING HOURS TO THE PUBLIC:
Monday, Wednesday, Friday:
from 8.30 to 13.30

The office provides information, collects reports and coordinates all the activities of Città Solidale.

SCIENTIFIC TECHNICAL COMMITTEE

FOR THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION

- Dr. Roberto Longo: Chairman
- Dr. Francesco Franza: Psychiatrist
- Dr. Francesco Colizzi: Psychiatrist
- Dr. Vincenzo Capozza: Neurologist/Psychiatrist
- Dr. Antonella Vacca: Psychologist
- Dr. Ivana Colizzi: Psychologist
- Dr. Giovanna Lucisani: Coordinator of the Psychosocial Rehabilitation Workshops
- Dr. Mario Vetrano: Coordination Manager, C.R.A.P. “Villa del Sole”
- Dr. Maria Cotrina Mingolla: Coordination Manager, Psychiatric Group Home “Casa Lilla”
- Dr. Massimiliano Chirulli: Coordination Manager, C.R.A.P. “Villa C. A. Dalla Chiesa”
- Dr. Francesca Mingolla: Coordination Manager, Casa per la Vita “F. Basaglia” and “G. Falcone”
- Dr. Irene Passiatore: Coordination Manager, R.S.A. for the disabled and Day Centre “Myosotis”
- Dr. Roberta Fortunato Priore: Coordination Manager, R.S.A. for the elderly “Rosa Aluisio”

Area of studies and research in therapeutic and psychosocial rehabilitation

The Cooperative's Scientific Technical Committee, which oversees the area of psychosocial rehabilitation and social and healthcare assistance, takes on board all the indications deriving from research, translating them into service practices in order to align care pathways with scientific evidence.

This is a multifaceted and complex process that requires constant evaluation and careful analysis of the context.

Education, training and the development of skills are fundamental requirements for the effectiveness of daily work; continuing professional development (for the acquisition of credits and/or ECM) through internal or external courses is therefore strongly encouraged and periodically monitored.

The Committee examines and discusses the effectiveness and efficiency of processes, keeping up to date through National and International Guidelines, Recommendations and Good Practices based on Evidence Based techniques.

Over time, structured tools have been tested for assessing and measuring patients' clinical and psychosocial problems and the outcome of residential and non-residential treatments, with particular reference to psychopathology, personal and social functioning, quality of life, rights and work potential, documenting the effectiveness of treatments, the course of the illness and possible recovery.

CARE AND SERVICES

Care and services are arranged over the course of the day according to the needs and requirements of the guests.

The multidisciplinary team, working in shifts, provides:

- Medical care: primary and specialist. Users are invited to choose a General Practitioner in the Municipality where the Community is located. On the basis of the Treatment Plan, the team arranges the supply of medicines from the contracted pharmacy and supports the user in booking specialist appointments and accompanies them to these.
- Nursing care: administration of medication, blood sampling, routine checks, various tests.
- Psychiatric and psychological care, aimed at conducting individual interviews, meetings with families, team meetings, meetings with users, and internal reviews of objectives, including with the referring Mental Health Centres or Social and Health Districts.
- Social care: upon admission into care, a key worker is identified from among the Community's educators, whom the user can turn to with any problem and to define appropriate solutions.
- Educational activities aimed at achieving independence and consolidating acquired skills.
- Rehabilitation activities for the acquisition or maintenance of cognitive, emotional-relational, social, recreational, sports, cultural, artistic and educational skills, participation in discussion meetings, social and work reintegration activities.
- Meals and personalised diet (breakfast, mid-morning snack, lunch, afternoon snack and dinner), in accordance with the nutritional plan indicated by the ASL. Staff on duty, who hold health suitability certification (HACCP), are responsible for preparation according to the daily menu drawn up by the nutritionist biologist. Where necessary (intolerances, allergies, metabolic

disorders) and on medical prescription, the diet is personalised.

- Linen available in adequate quantities, sanitised by an industrial laundry.
- Annual holidays at the seaside and/or in the mountains, trips and guided excursions.
- Religious care: the community gives due consideration to this human dimension, liaising with local religious communities and volunteer groups.
- Relations with families and the local area: community staff look after relations with family members and ensure the social integration of users by promoting collaboration with voluntary associations. Family members' opportunity to communicate with staff about the health of their relative is guaranteed through meetings to be requested on days and at times set weekly.
- Individual and group psychotherapeutic interventions, also targeting psychopathological aspects that require specific interventions, such as managing impulsivity and dysfunctional behaviours often linked to severe personality disorders.
- Rehabilitation of offender users subject to security measures who require long-term therapeutic interventions of high rehabilitative intensity due to the persistence of severe psychopathological conditions. In this case the Rehabilitation Team works in liaison with the Judicial Authority and the UEPE, as well as with lawyers and any support administrators.
- Collaboration with law enforcement agencies and the judicial authorities.
- The Cooperative seeks to encourage the involvement of family members in the management of clinical activities, considering their role central to achieving and maintaining the psychophysical well-being of the guests. Specific family treatment pathways are arranged by the facility's team.
- To obtain health records held by the Community, the guest and/or any other entitled person submits a request to the Community Coordination Manager and to the Medical Director, who will provide the requested information within 30 days. A meeting with the Medical Director may be requested at any time for information on the guest's state of health.

HEALTH AND HYGIENE REGULATIONS

The Cooperative meets the requirements laid down by current regulations on town planning, building, fire prevention, hygiene and safety, pursuant to Article 9, paragraph 1, letter c) of Law no. 328 of 2000.

Legislative Decree (D.Lgs.) 81/2008 as subsequently amended and supplemented brings together in a single text the existing rules on health and safety in the workplace; in particular, Legislative Decree of 9 April 2008, no. 81 implements Article 1 of Law no. 123 of 3 August 2007 on the protection of health and safety in the workplace

In Italy, HACCP legislation is governed by Legislative Decree no. 193/2007. This decree transposed European legislation on food hygiene (Regulation (EC) no. 852/2004) and established the mandatory requirements for implementing the HACCP system in all food businesses. The Organisation manages food safety through an "HACCP Management System", implementing a «process control» system that identifies the possibility of risks occurring during food handling and the related corrective actions.

In addition, the Cooperative periodically trains staff on hygiene rules and the prevention of food contamination in accordance with the guidelines of Regulation (EC) no. 852/2004, Legislative Decree no. 193/2007 and Regulation (EU) 2021/382.

THEORETICAL MODEL OF PSYCHIATRIC REHABILITATION

A cornerstone of the DSM's rehabilitation policy, as set out in the Mental Health Service Charter of Brindisi, is the psychosocial recovery of the user through integration into the local area (in the community), respecting the fundamental rights and dignity of the person.

In operational terms, the objective of psychosocial rehabilitation is to improve individual skills and introduce environmental changes so as to create the conditions for a good quality of life for a person who has had mental disorders and suffers their consequences.

Guidance on the intensity of rehabilitation treatment and on the level of care derives both from psychopathological aspects (severity and complexity of the clinical picture, clinical stability) and from the level of psychosocial functioning. The aim is to identify an appropriate response to the patient's specific needs by establishing a correlation on two levels:

- The level of therapeutic rehabilitation intervention required: *rehabilitation intensity*;
- The level of care needed: *care intensity*.

The extended stress-vulnerability model also includes *Recovery*, understood as "recovery, resumption" from mental illness (Coleman 2001), in terms of how the person with mental illness functions in their role within their own social context, resulting in a perception of well-being and a reduction in

symptoms. Recovery can be defined as a process that evolves over time, arising from the interplay between personal factors (such as motivation and skills development) and supportive environmental factors (material resources, the role of mental health services, social network), complemented by involvement in meaningful activities and social roles, which give the dimension of interaction between the individual and the environment (Wilken 2007).

The model therefore highlights the importance of supporting the user's active role in treatment, particularly in achieving the desired outcomes, in choosing treatment methods and in helping people develop illness self-management skills in order to pursue their own goals.

The proposed model is therefore a *bio-psycho-social*model, which suggests that mental health problems are influenced by multiple domains of human experience, such as the biological-medical, the psychological-mental and the social-spiritual.

To be effective, rehabilitation must follow certain guidelines:

- the use and/or development of environmental resources
- the improvement of the patient's abilities, namely the development of social skills that enable the person to be effective and successful, according to their own lifestyle within the context of society.
- the possibility of integrating the rehabilitation experience with social and work inclusion within local communities;
- awareness-raising and involvement of the local area.

The place of rehabilitation, whether public or private, residential or semi-residential, is a meeting point of skills at the service of the user; it is a place for in-depth understanding of their needs and of their potential or residual abilities; it is the place of their growth and emancipation, where there is no room for non-specific entertainment in their recovery. In the field of psychosocial rehabilitation and of mental health in general, it is in fact a priority to translate the indications deriving from research into service practices and to align care pathways with scientific evidence.

Among the various rehabilitation activities, with a view to the appropriateness of interventions, “Evidence based” techniques have been chosen above all, i.e. those based on scientific evidence and proof of effectiveness, such as Cognitive Rehabilitation, “Social skills training”, “Psychoeducation” and DBT (Dialectical Behaviour Therapy).

The other activities carried out are both structured and unstructured: from workshop activities, whose purpose is specifically therapeutic and rehabilitative, to leisure, games and rest; there are numerous external activities: from taking part in traditional events (patron saint festivals, local food festivals, town shows and events) to excursions and holiday stays. Despite the success of pedagogical approaches and of techniques derived from cognitive behavioural therapy, the most original aspect of rehabilitation is still to be found in the way the various techniques are combined; indeed, only a complete range of programmes accessible to the patient can improve social functioning and, above all, maintain it**.**

It appears essential, for every practice to be designed and implemented, to adopt an evaluation methodology that addresses “what is done and how” (process evaluation) and “what is achieved” “outcome evaluation”). The evaluation process may apply to the validity and consistency of models and to the effectiveness of techniques and programmes from an “evidence-based” perspective, or may concern the evaluation of rehabilitation services and programmes (Burti 2003).

To this end, the ICF (International Classification of Functioning, Disability and Health) has been used as the main tool for identifying and assessing rehabilitation goals. The ICF is the tool developed by the World Health Organization to describe and measure the level of health and disability in the population, and it is the one that best fits the bio-psycho-social model of mental disorders, moving beyond the biomedical model according to which illness can be explained as a deviation from the norm of measurable biological variables.

The choice to use this tool stems from the fact that the ICF makes it possible to describe a person's functioning profile using a universal language, in which the level of functioning within the illness can be described. In this model the medical diagnosis is seen as the interaction of biological, psychological and social aspects in assessing the individual's state of health and prescribing appropriate treatment; for this reason it is divided into two components: the first part describes Functioning and Disability, through the description of Body Functions and Structures and of Activities and Participation; the second part describes Contextual Factors, divided into Environmental Factors and Personal Factors.

This tool makes it possible to focus on relationships, introducing the environmental component as a barrier or facilitator. The aim is to provide a global view of the person rather than of the illness, focusing on developing their abilities and on a supportive environmental context. The approach is no longer oriented towards delivering services but towards achieving the greatest possible independence.

When defining functioning profiles, other specific assessment tools may be used as a complement and support, assessing psychopathological aspects (BPRS), cognitive level (MMSE), intelligence quotient (WAIS, TIB), personal and social functioning (VADO FPS Scale, VGF scale) and, in the case of offender patients, social dangerousness (HCR-20), resources (SAPROF) and impulsivity (BIS-11).

THE WORKSHOP NETWORK

CONTACT PERSON: Dr. GIOVANNA LUCISANI

The workshops have specific rehabilitation objectives to be monitored and achieved, within a project drawn up by the rehabilitation team staff that takes into account the objectives of each user's individual PTR.

The workshops are open to guests and external volunteers. They involve the presence of instructors and educators in numbers proportionate to the number of participants. Responsibility for the workshops is entrusted to Staff who are experts both in the specific discipline of the Setting and in the management of psychosocial rehabilitation methodologies. The activity is planned in advance, including the provision of materials. Operating hours must be respected and the active participation of attendees is always encouraged.

The **Rehabilitation Workshops**, active both inside and outside the community according to a weekly schedule, are:

- Health Psychoeducation
- Domestic Psychoeducation
- Emotional Psychoeducation
- Financial and Asset Psychoeducation
- Family Psychoeducation
- Psychoeducation
- Social Skills Training and cognitive training
- Cognitive rehabilitation

- Active Citizenship
- Basic Knowledge
- Musical Communication
- Art Workshop
- Maintenance Workshop
- Cooking and pastry-making
- Horticultural Therapy
- Physical Activities
- Physiotherapy
- Dance Therapy
- Five-a-side Football
- Theatre
- Painting
- Photography
- Music and Art Therapy
- Digital Independence
- Relations with the local area
- Job placement

The Workshops are divided according to the Quality of Life domains (WHO):

For the area of Emotional Well-being, the following workshops are active:

• **Emotional Psychoeducation**: using Falloon's evidence based technique, users can be guided to acquire the capacity for “emotional regulation” (Gross). The pathway involves recognising the different emotions (Ekmann), self-control and the management of one's own moods and the related behaviours in the environment. The workshop offers the opportunity to express healthier emotional behaviours and helps users discover alternative ways of thinking and feeling, and of dealing with specific emotional experiences, relational issues and personal problems, in a protected setting in which they learn to use their imaginative and creative abilities to solve problems rather than complicating them with unwanted emotions. The challenge is to educate in emotions (Goleman) because only by preparing users to manage their emotional world correctly will they be able to draw on the inner resources needed to live

as well as possible and to relate to others in a balanced and serene way. This workshop also includes the practice of mindfulness, long known for its empirical effectiveness in addressing anxiety disorders, depressive disorders, conditions linked to social-relational difficulties, pathological impulsivity and emotional distress in general.

• **Painting**: the main objective of the Painting and Creative Recycling Workshop is to use artistic expression (painting) and manual re-creation (creative recycling) as vehicles for expressing one's inner world, strengthening the sense of self-efficacy and promoting social integration through the production of objects that are useful for oneself and for the community. In particular, it aims to: encourage the free expression of emotions, thoughts and experiences through the language of art; stimulate creativity, manual skills and planning abilities; strengthen confidence in one's own abilities through the creation of tangible products; promote the conscious reuse of materials, developing environmental awareness; foster collaboration, sharing and social integration through individual and group activities.

• **Photography:** the Photographic Composition Workshop aims to promote personal well-being and psychosocial integration through the use of photography as a tool for exploration, expression and sharing. The symbolic theme of the “journey”, understood both as an outward experience and as an inner path, is the common thread running through the workshop experience. Photography is offered not merely as a means of representing reality, but as a tool for observation and conscious choice: composing an image in fact means deciding what to look at, what to include or exclude, from which point of view to observe and what meaning to attribute to what one encounters.

• **Music psychoeducation** is carried out using sound/music as the preferred mediator on an expressive and relational level. Activities include moments of shared listening to pieces brought by users, alternating with selections offered by the person in charge, and moments of free improvisation. A music teacher guides the group towards the goal of finding the rhythmic balance of the body as it constantly moves through space and time. The use of rhythm instruments in particular will contribute to this aim and will help to recover lost time, to coordinate the body in space, and to regulate the rhythmic pulse of the heart and of breathing.

• **Art Workshop**: The art workshop aims to develop manual and creative skills through the handling, decoration and production of various objects. It makes it possible to carry out a process of analysis, planning, control and verification through the observation and choice of the materials to be used. Users

express their creativity through different techniques (decoupage, sewing, costume jewellery, decoration, stencilling, etc.) to create a wide variety of objects.

The Physical Well-being area includes the following workshops:

• **Health Psychoeducation:** takes place daily within the Community and guides users in maintaining and recovering skills and in the proper management of themselves, their health and their hygiene, taking into account the minimum competences needed for self-sufficiency in the instrumental activities of daily living. The workshop leader helps the user carry out the task by breaking activities down into small actions. The actions are planned on an individual basis and are entrusted to staff who lead the experience and monitor changes. The Recovery and Empowerment Model (Anthony, 1993): emphasises the centrality of the person, the right to know about one's own condition and the possibility of building a meaningful life path beyond the diagnosis.

• **Physical Activities:** during the workshop users perform light physical exercises, warm-ups, stretching, and simple games with a ball and some equipment. As well as combating the bad habit of a sedentary lifestyle, users have the opportunity to adopt a healthy lifestyle. It is an established fact that physical activities produce beneficial effects on both the mental and the physical sphere of individuals. By acting on physical and psychosocial conditions, physical activity improves patients' daily lives. In general, physical activities optimise the individual's physical condition, having a preventive function against the onset of certain diseases.

• **Physiotherapy:** is a structured rehabilitation intervention aimed at maintaining and enhancing residual motor abilities, preventing functional decline and promoting the Guest's psychophysical well-being. The activity forms part of each resident's Individualised Care Plan (PAI) and is scheduled on the basis of an initial functional assessment carried out by the physiotherapist in collaboration with the multidisciplinary team. Rehabilitation objectives are defined on a personalised basis.

The Material Well-being area includes the following workshops:

• **Financial and asset psychoeducation:** the financial and asset psychoeducation programme is designed to provide practical, easy-to-understand support for managing one's own financial resources and assets independently or with support. Through structured sessions, always adapted to each person's needs and abilities, the programme offers practical tools and basic knowledge for

understanding the value of money, planning a budget, and recognising spending priorities and financial risks. Particular attention is devoted to financial autonomy, asset protection and fraud prevention. The programme aims to enhance decision-making autonomy, improve self-confidence and the ability to manage complex financial situations, and also to facilitate dialogue with families, staff and legal support figures.

Within rehabilitation practice, **job placement**, where possible, is a fundamental element in the integrated treatment of the patient in the community and in their social inclusion. For a person with mental health problems, work takes on particular meanings: it enables and fosters a better structuring of personal identity and a better relational life, the acquisition and exercise of specific competences and skills, the earning of an income, the recovery of a social role, and active and participatory reintegration into one's own community, reaffirming the right of citizenship and countering any form of prejudice leading to marginalisation and exclusion. Job placement is therefore fully part of the individual therapeutic plan, also drawing on local resources and regional policies.

The Personal Development area includes the following workshops:

• **Domestic Psychoeducation:** The domestic education workshop aims to provide the skills needed for self-sufficiency in the activities of daily living. Domestic tasks are carried out in the Community throughout the day, alongside the tidying of the Community and mealtimes. This activity is preparatory to self-sufficiency and instrumental to the activities of daily living. It is based on a daily schedule that plans the various activities for managing individual and shared spaces, with the aim of involving all users in every phase (the daily schedule is posted on the Community notice board).

• **Cognitive Rehabilitation:** aims to improve and/or restore impaired cognitive functions using a wide range of strategies using a wide range of strategies, such as Integrated Psychological Therapy (by Brenner et al.), Cognitive Remediation Therapy (by Wykes et al.) and Integrated Neurocognitive Therapy (by Roder et al.). Cognitive deficits are a negative predictor of the individual's psychosocial and occupational functioning and quality of life, as well as a factor limiting the success of rehabilitation interventions. Most cognitive remediation techniques target the functions most closely correlated with the patient's disabilities: executive functions, memory and attention. Changing cognitive performance

is a primary goal of cognitive remediation techniques; however, the main objective is the improvement of the user's overall functioning and quality of life.

• **Basic knowledge:** is a structured rehabilitation intervention for Guests with cognitive and/or multiple disabilities, aimed at maintaining and enhancing academic skills and basic functional competences. The activity forms part of individualised rehabilitation planning and provides a space for targeted cognitive stimulation, focused on making the most of residual abilities and strengthening personal autonomy. The workshop offers activities tailored to each participant's level of functioning, with reading and writing exercises, recognition of letters and numbers, simple arithmetic, spatial and temporal orientation and understanding of instructions. Activities are adapted through visual aids, facilitating materials and compensatory tools, fostering concrete and meaningful learning. The workshop helps to maintain attention and memory functions, strengthens the sense of self-efficacy and supports active participation in the daily life of the facility. In a welcoming and reassuring atmosphere, the activity becomes not only a moment of learning, but also an opportunity for relationships, stimulation and the valuing of the person.

• **Psychoeducation:** this evidence-based technique developed by Falloon guides users in the proper management of themselves, their health and their hygiene, taking into account the minimum competences needed for self-sufficiency in the instrumental activities of daily living. Topics addressed include nutrition education, managing smoking and its consequences, money management and the management of drug therapy. It provides useful guidance for achieving a healthy lifestyle through information sessions, physical exercise and the setting of personal life goals.

The Interpersonal Relationships area runs the following workshops:

• **Theatre:** the theatre activity offered is a path of expressive growth, in which all those involved, personally and in turn, will become creators/communicators and spectators, discovering rules and mechanisms but also, and above all, personal possibilities.

The possibility of achieving one's best according to one's own potential and abilities, bringing into play unknown or repressed aspects of oneself, and the positive use of energy in order to "do" are all aspects that give a positive character to the function of theatre-based activities.

The purpose of this activity is not so much the performance itself, which must nonetheless be tackled and managed to give meaning and value to the work, but rather what the process reveals of each

person's own, highly personal creative and communicative abilities, which become part of everyone's personal baggage.

• **Musicarterapia:** builds a connection between graphic, chromatic, bodily, plastic, musical and linguistic expression, involving the entire educational-therapeutic project, both in expression and in enjoyment. The Globalità dei Linguaggi (GdL – Globality of Languages) is a training discipline in communication and expression with aims of research, education, animation, rehabilitation and therapy, devised by Stefania Guerra Lisi.

• **Dance therapy:** (or Dance Movement Therapy) is an expressive, body-based discipline that uses movement and dance as means of communication, expression and mind-body integration. In the psychiatric setting, dance therapy fosters reconnection with one's own body, improved self-esteem, emotional regulation and socialisation. It is based on a mind-body, relational and creative approach, in which each person is free to explore movement according to their own possibilities and limits.

• **Five-a-side football:** football is an important metaphor for teamwork: people work together, coordinate with one another and pursue a common goal. It is a practical way to explore the world, avoid isolation, consolidate friendships and make the best use of one's body. The five-a-side football workshop, held in a protected and supervised setting, is an educational and therapeutic tool that helps Guests manage their emotions, respect rules and strengthen their social and relational skills. Through team play, participants are encouraged to experience dynamics of collaboration, trust and belonging, in a non-competitive environment focused on mutual support. Football as a metaphor for life has an educational character and takes on rehabilitative value. The focus shifts from limitations to resources, and from dysfunctions to the participants' strengths.

• **Family Psychoeducation:** this evidence-based technique developed by Falloon guides family members and caregivers towards a greater understanding of the difficulties of the person affected by the illness, enabling them to acquire techniques and approaches for communicating effectively with that person.

The Self-determination area runs the following Workshops:

• **Social Skills Training (S.S.T.) and Cognitive Training:** is a well-known Evidence-Based technique that can be practised within an interpersonal relationship, one-to-one or preferably in a group, between staff and users, in a climate of open collaboration and mutual trust. Through a set of psychoeducational techniques, individuals are systematically helped to develop more effective skills for interacting with

others. Scientific research firmly states that all social behaviours can be learned, and therefore modified, through experience and training. These techniques are based on a series of social learning principles such as modelling, reinforcement, shaping, automatisation and generalisation.

• **Cooking and Pastry-making:** the workshop aims to give participants practical skills for daily life while at the same time strengthening motivation, responsibility and food awareness. The programme combines the practical dimension of cooking with personal growth, promoting psychological well-being through manual activity, collaboration and contact with food. It is structured with the aim of planning recipes based on the principles of nutrition education, hygiene and knowledge of products.

• **Horticultural therapy:** Horticultural Therapy, or ortoterapia, a translation of the original English term Horticultural Therapy, is based on the scientifically proven premise that contact with nature, even the simple sight of a green landscape, has beneficial effects on the individual. Through contact with the soil, people experience a unique and simple way of caring for plants. Growing a crop instils a sense of pride and satisfaction, develops a sense of responsibility, and stimulates cognitive and social skills. Beautifying a garden also helps to stimulate creativity and imagination, thereby strengthening confidence and self-esteem and enhancing relationships with others. Outdoor manual activity offers the opportunity to experience gestures and operations first-hand and to observe what happens. Guests are encouraged to use their senses to get in touch with nature and to develop various skills, such as exploration, observation and manipulation.

• **Maintenance Workshop:** the maintenance workshop aims to help participants acquire skills in furniture restoration, the creation of wooden objects and the recovery of second-hand items. Guests will first source waste materials such as pallets, old furniture, frames, chairs, etc., and then, depending on the object, plan a restoration and give the object a new identity. The re-created objects may be used to decorate the various local units and/or be sold at markets.

• **Digital Autonomy:** was created to offer people with psychiatric disorders the opportunity to acquire basic computer and digital skills, thereby fostering autonomy, social participation and inclusion. In an increasingly connected world, knowing how to use computers, smartphones and the internet is not just a technical skill but a genuine tool for personal empowerment. Through a gradual and guided path, participants learn to use digital technologies in a conscious, safe and creative way, improving

communication, the management of daily life and their relationship with the outside world. The workshop combines theory and practice: it starts with the basics of IT and computer use and moves on to browsing the internet, using social media safely, and creating simple multimedia content (texts, images, videos). The aim is to reduce the digital divide, promote personal autonomy and enhance individual potential through a positive experience of technology.

The Social Integration area runs the following Workshops:

• **Relationship with the local area:** the workshop offers a protected and stimulating space in which to learn to find one's way around everyday spaces, get to know useful and meaningful places in one's local area and take part in guided outings that foster autonomy, confidence and connection with the community. Through maps, neighbourhood routes, practical exercises and planned trips, participants progressively develop the ability to: recognise visual landmarks, use simple tools such as maps or navigation apps, and find their way in both familiar and new settings. The outing experience (trips) becomes a concrete opportunity to put the skills learned to the test, helping to reduce anxiety about finding one's way, feelings of disorientation or dependence on others. The workshop proceeds gradually, always accompanied by staff, in a setting that values success, exploration, curiosity and the relationship with the environment.

The Rights area runs the following Workshops:

• **Active Citizenship:** the Active Citizenship (Rights and Legality) workshop is an educational and rehabilitation programme aimed at promoting awareness of oneself as a holder of rights and duties, encouraging the assumption of personal and social responsibility. Through experiential activities, guided discussions, practical workshops and meetings with experts, the programme aims to develop a concrete understanding of civic life: respect for rules, justice, solidarity, legality and the conscious exercise of rights. The workshop takes a non-judgemental approach, focused on rebuilding a sense of belonging and on personal responsibility as part of the social reintegration process**.**

•**Community Meeting:** every month the users of the Community, guided by an educator who acts as facilitator and moderator, meet to discuss a wide range of topics: from matters of collective interest concerning community life, the menu, diet, the rules of living together, the organisation of social evenings and trips, free outings, etc. By listening and speaking, users engage with others and learn to

examine issues and to question themselves, regaining full autonomy and exercising active citizenship.

THE REHABILITATION AND CARE FACILITIES

PSYCHIATRIC RESIDENTIAL CARE COMMUNITY

"VILLA DEL SOLE"

The facility

The Psychiatric Rehabilitation and Care Community (CRAP) is located in Latiano (BR) at via Giuseppe Di Vittorio n.3. The Coordination Manager is Dr. Mario Vetrano, Senior Healthcare Professional Collaborator; the Medical Director is Dr. Francesco Franza, Psychiatrist; the Consultant Psychiatrist is Dr. Francesco Colizzi; the Psychologist is Dr. Ivana Colizzi, Psychotherapist.

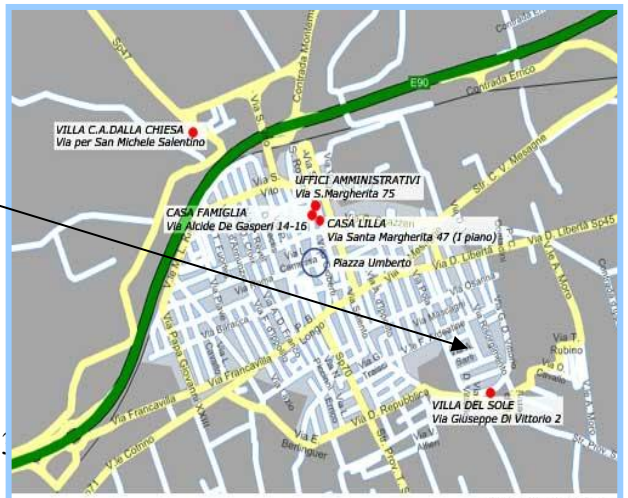
Contact numbers: Community 0831 – 721329, Company mobile 3936733062.

Email: villadelsole.latiano@gmail.com; vds@cittasolidale.net

Institutionally accredited by the National Health Service by Executive Decree (D.D.) of the APS Service of the Puglia Region no. 310 of 09.12.2013, previously authorised to operate by the Municipality of Latiano by D.D. no. 1654 of 31.12.2004.

It holds UNI EN ISO 9001:2015 Quality Certification.





Simplified Floor Plan

It is built on four floors, free of architectural barriers, surrounded by balconies and a garden, and with spaces suited to recreational and leisure activities. It is located in the Pigna area of Latiano, near the swimming pool and the park, which facilitates socialisation and integration.

Double bedrooms	7
Staff room	1
Guest bathrooms	6
Staff bathrooms	1
Bathrooms for the disabled	2
Rooms for psychosocial activities	1
Meeting room	1
Dining room	1
Kitchen	1
TV room	1
Recreation room	1
Laundry	1

Furnishings and equipment

In order to meet the Guests' needs appropriately, the Community is furnished and equipped with all the comforts and features of a normal home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to ensure that the Community always functions properly.

Who it is for

The CRAP is a therapeutic and rehabilitative residential facility for acute and sub-acute patients (R.R. no. 3 of 2005), with care cover 24 hours a day; it accommodates 14 individuals with severe relational difficulties or impaired basic autonomy, who require highly qualified therapeutic interventions.

Aims

The multi-professional and multidimensional management of the Community aims to tailor rehabilitation planning to each individual with mental distress, so that they can achieve the best possible level of mental, physical, social and emotional functioning. It promotes psychosocial skills in relationships, social integration and, where possible, re-entry into the world of work, with a view to leaving the care/therapeutic/rehabilitation pathway.

The Rehabilitation Team

Work is organised according to the multidisciplinary team model: each member takes part in drawing up treatment plans and assesses their progress during periodic meetings held at least every 15 days.
- The Medical Director, a psychiatrist, provides 12 hours per week of medical and psychiatric activity, scheduled according to the monthly calendar posted on the Community noticeboard. He supervises the staff and the Team in the rehabilitation of patients, works with GPs and specialists, and draws up the Therapeutic Plan on the basis of overall assessments of their mental and physical health.

- The Psychologist provides 12 hours per week of psychological activity, scheduled according to the monthly calendar posted on the Community noticeboard. She maintains relations with the Mental Health Services and works with them and with the staff in drawing up individual rehabilitation projects.

- The Coordination Manager, a senior healthcare professional, works during the day on weekdays, from Monday to Saturday, for a total of 36 hours per week, and is present at the facility for at least 6 hours a day. He or she is responsible for organising the Community and its staff, manages the facility's assets and the Guests' personal belongings, monitors the quality of the services provided, and oversees the management of the Guests' therapeutic and rehabilitation projects.

- The Healthcare Professionals (Social Workers, Psychiatric Rehabilitation Therapists, Professional Healthcare Educators and Nurses), 9 in number, ensure their presence around the clock, on the basis

of monthly rotas covering day and night hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They observe and record individual and group behaviour and hold ongoing interviews with users in order to carry out rehabilitation interventions.

- The Social and Healthcare Workers (OSS), 5 in number, ensure their presence around the clock, again on the basis of monthly rotas covering day and night hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They provide domestic, care and hygiene/health services aimed at maintaining the Guests' functional autonomy.

The morning shift usually starts at 8:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 21:00, while the night shift starts at 21:00 and ends at 8:00 the following day.
Times may also vary by one or two hours at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest's therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.
Each day shift must ensure the presence of at least 3 staff members, from among social and healthcare workers and healthcare professionals. At night, the presence of 1/2 staff members from among social and healthcare workers and healthcare professionals will be scheduled.

- 1 Medical Director / Psychiatrist
- 1 Psychologist
- 1 Senior Healthcare Professional - Coordinator
- 9 Healthcare Professionals (Social Workers, Psychiatric Rehabilitation Therapists, Professional Healthcare Educators and Nurses)
- 5 OSS

In order to offer the Guests of the CRAP a higher-quality service, the staff includes the following additional members:

- 1 Cook;
- 1 Administrative Manager;
- 1 Administrative Officer;
- 1 Human Resources Manager.

Community Life

Unless otherwise required for therapeutic reasons or for activity planning purposes, Community life is

generally organised as follows:

6.30 Wake-up

07.00 – 07.45 Breakfast

Drug therapy

8.30 – 9.30 Care and cleaning of personal living space and common areas

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.30 Rehabilitation Workshops, activities and/or outings

19.00 Dinner and tidying of the dining room

Drug therapy

20.00 Free Time (TV, board games, etc.)

22.00 Night rest

Rehabilitation

The multidisciplinary team provides care 24 hours a day.

Each Guest has an Individual Therapeutic Rehabilitation Plan (PTRI), drawn up by the Mental Health Centre (CSM). On the basis of this plan, the Community team sets the medium- and long-term goals to be achieved, in agreement with the Guest. If the referral comes directly from the Judicial Authority, the Team, starting from the prescriptions laid down, shares the case with the referring CSM, seeking the right balance between rehabilitation and supervision with a view to the patient's care and rehabilitation.

After an initial period of adjustment, the Guest must follow the therapeutic rehabilitation programme proposed to them, attending the workshops set out in their PTRI and taking part in the activities organised by the team (group outings with a therapeutic purpose, individual and group interviews, internal meetings); they must also take their medication regularly and show good treatment compliance.

Community Rules

Each Guest has their own private space, which they can personalise, and makes use of common areas in which to feel welcome and at ease.

All Guests are required to take care of themselves and their clothing: staff will point out any shortcomings and provide support where abilities are reduced.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open and Guests may go out at any time; however, outings are limited by participation in the Community's rehabilitation activities and/or by any therapeutic prescriptions issued by the Judicial Authority, the Mental Health Centre or the Community team. Generally, Guests may go out from 10.00 to 12.30 and from 16.30 to 19.00, after informing the staff on shift. Any exceptions will be dealt with by the Community team. Guests who are not clean and well groomed are advised not to go out.

The Community has a landline through which calls can be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the Community team.

All Guests may receive visits from relatives and friends. However, such visits must not interfere with rehabilitation and work activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and the reception of visitors in certain areas should be mediated by a staff member, who will check beforehand that they are accessible.

Visits are generally possible from 10.00 to 12.00 and from 16.00 to 18.00. in some cases, visiting times and arrangements are governed by the therapeutic rehabilitation project and must be agreed with the Community team.

PSYCHIATRIC RESIDENTIAL CARE COMMUNITY

"VILLA CARLO ALBERTO DALLA CHIESA"

The facility

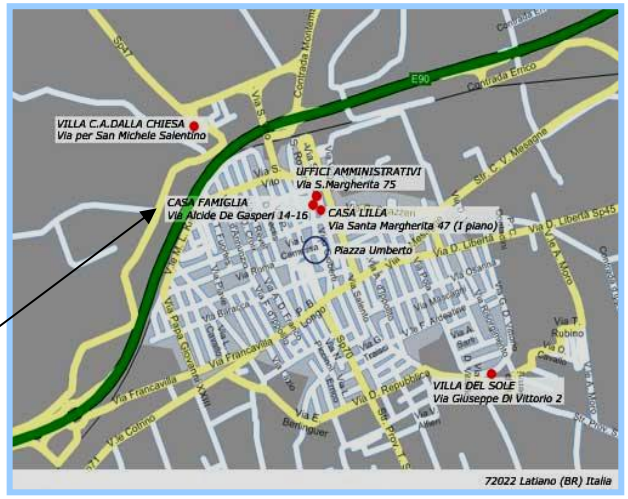
The Psychiatric Residential Care Community (CRAP) is located in Latiano (BR), on the provincial road to San Michele Salentino. The Coordination Manager is Dr. Massimiliano Chirulli, Senior Healthcare Professional; the Medical Director is Dr. Francesco Franza, Psychiatrist; the Consultant Psychiatrist is Dr. Vincenzo Capozza; the Psychologist is Dr. Antonella Vacca, Psychotherapist.

Contact numbers: Community 0831 – 721001, Company mobile 3937456170.

Email: vdc@cittasolidale.net

Institutionally accredited by the National Health Service by Executive Decision (D.D.) of the APS Service of the Puglia Region no. 276 of 12.10.2015, previously authorised to operate by the Municipality of Latiano by D.D. no. 1656 of 31.12.2004.
It holds UNI EN ISO 9001:2015 Quality Certification.





Simplified Floor Plan

It is a villa surrounded by greenery, located on the ground floor, free of architectural barriers and with spaces suitable for recreational and leisure activities.

Double bedrooms	7

Staff room	1
Guest bathrooms	6
Staff bathrooms	1
Bathrooms for the disabled	2
Rooms for psychosocial activities	1
Meeting room	1
TV room	1
Dining room	1
Kitchen	1

Furnishings and equipment

In order to meet the Guests' needs appropriately, the Community is furnished and equipped with all the comforts and features of a normal home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to ensure that the Community always functions properly.

Who it is for

The C.R.A.P. is a therapeutic and rehabilitative residential facility for acute and sub-acute patients (R.R. no. 3 of 2005), with care cover 24 hours a day; it accommodates 14 individuals with severe relational difficulties or impaired basic autonomy, who require highly qualified therapeutic interventions.

Aims

The multi-professional and multidimensional management of the Community aims to tailor rehabilitation planning to each individual with mental distress, so that they can achieve the best possible level of mental, physical, social and emotional functioning. It promotes psychosocial skills in relationships, social integration and, where possible, re-entry into the world of work, with a view to leaving the care/therapeutic/rehabilitation pathway.

The Rehabilitation Team

Work is organised according to the multidisciplinary team model: each member takes part in drawing up treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Medical Director, a psychiatrist, provides 12 hours per week of medical and psychiatric activity, scheduled according to the monthly calendar posted on the Community noticeboard. He supervises the staff and the Team in the rehabilitation of patients, works with GPs and specialists, and draws up the Therapeutic Plan on the basis of overall assessments of their mental and physical health.

- The Psychologist provides 12 hours per week of psychological activity, scheduled according to the monthly calendar posted on the Community noticeboard. She maintains relations with the Mental Health Services and works with them and with the staff in drawing up individual rehabilitation projects.

- The Coordination Manager, a senior healthcare professional, works during the day on weekdays, from Monday to Saturday, for a total of 36 hours per week, and is present at the facility for at least 6 hours a day. He or she is responsible for organising the Community and its staff, manages the facility's assets and the Guests' personal belongings, monitors the quality of the services provided, and oversees the management of the Guests' therapeutic and rehabilitation projects.

- The Healthcare Professionals (Social Workers, Psychiatric Rehabilitation Therapists, Professional Healthcare Educators and Nurses), 9 in number, ensure their presence around the clock, on the basis of monthly rotas covering day and night hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They observe and record individual and group behaviour and hold ongoing interviews with users in order to carry out rehabilitation interventions.

- The Social and Healthcare Workers (OSS), 5 in number, ensure their presence around the clock, again on the basis of monthly rotas covering day and night hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They provide domestic, care and hygiene/health services aimed at maintaining the Guests' functional autonomy.

The morning shift usually starts at 8:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 21:00, while the night shift starts at 21:00 and ends at 8:00 the following day.

Times may also vary by one or two hours at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest's therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.

Each day shift must ensure the presence of at least 3 staff members, from among social and healthcare workers and healthcare professionals. At night, the presence of 1/2 staff members from among social and healthcare workers and healthcare professionals will be scheduled.

- 1 Medical Director / Psychiatrist
- 1 Psychologist
- 1 Senior Healthcare Professional - Coordinator
- 9 Healthcare Professionals (Social Workers, Psychiatric Rehabilitation Therapists, Professional Healthcare Educators and Nurses)
- 5 OSS

In order to offer the Guests of the CRAP a higher-quality service, the staff includes the following additional members:

- 1 Cook;
- 1 Administrative Manager;
- 1 Administrative Officer
- 1 Human Resources Manager

Community Life

Community life takes place both inside and outside the facility. Unless otherwise required for therapeutic reasons or for activity planning purposes, Community life is generally organised as follows:

6.30 Wake-up

07.00 – 07.45 Breakfast

Drug therapy

8.30 – 9.30 Care and cleaning of personal living space and common areas

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.30 Rehabilitation Workshops, activities and/or outings

19.00 Dinner and tidying of the dining room

Drug therapy

20.00 Free Time (TV, board games, etc.)

22.00 Night rest

Rehabilitation

The multidisciplinary team provides care 24 hours a day.

Each Guest has an Individual Therapeutic Rehabilitation Plan (PTRI), drawn up by the Mental Health Centre (CSM). On the basis of this plan, the Community team sets the medium- and long-term goals to be achieved, in agreement with the Guest. If the referral comes directly from the Judicial Authority, the Team, starting from the prescriptions laid down, shares the case with the referring CSM, seeking the right balance between rehabilitation and supervision with a view to the patient's care and rehabilitation.

After an initial period of adjustment, the Guest must follow the therapeutic rehabilitation programme proposed to them, attending the workshops set out in their PTRI and taking part in the activities organised by the team (group outings with a therapeutic purpose, individual and group interviews, internal meetings); they must also take their medication regularly and show good treatment compliance.

Community Rules

Each Guest has their own private space, which they can personalise, and makes use of common areas in which to feel welcome and at ease.

All Guests are required to take care of themselves and their clothing: staff will point out any shortcomings and provide support where abilities are reduced.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open and Guests may go out at any time; however, outings are limited by participation in the Community's rehabilitation activities and/or by any therapeutic prescriptions issued by the Judicial Authority, the Mental Health Centre or the Community team. Generally, Guests may go out from 10.00 to 12.30 and from 16.30 to 19.00, after informing the staff on shift. Any exceptions will be dealt with by the Community team. Guests who are not clean and well groomed are advised not to go out.

The Community has a landline through which calls can be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the Community team.

All Guests may receive visits from relatives and friends. However, such visits must not interfere with rehabilitation and work activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and the reception of visitors in certain areas should be mediated by a staff member, who will check beforehand that they are accessible.

Visits are generally possible from 10.00 to 12.00 and from 16.00 to 18.00. in some cases, visiting times and arrangements are governed by the therapeutic rehabilitation project and must be agreed with the Community team.

PSYCHIATRIC GROUP HOME

"CASA LILLA"

The facility

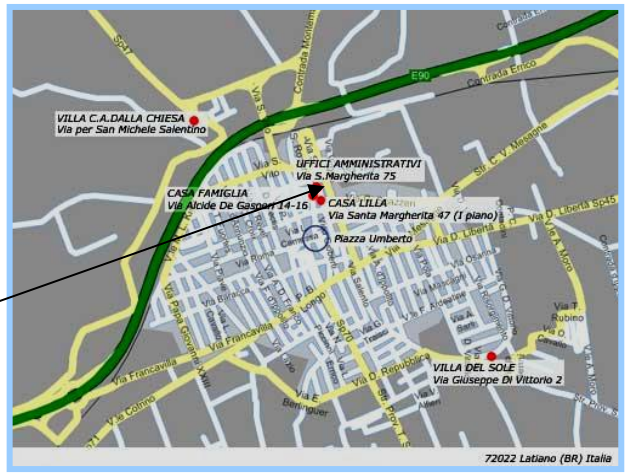
The Psychiatric Group Home is located in Latiano (BR) at via Santa Margherita, 47 P.1. The Coordination Manager is Dr. Maria Cotrina Mingolla, Senior Healthcare Professional; the Medical Director is Dr. Francesco Franza, Psychiatrist; the Consultant Psychiatrist is Dr. Francesco Colizzi; the Psychologist is Dr. Ivana Colizzi, Psychotherapist.

Contact numbers: Community 0831 – 727070, Company mobile 3937419229.

Email: casalilla@cittasolidale.net

Institutionally accredited by the National Health Service by Executive Decision (D.D.) of the APS Service of the Puglia Region no. 293 of 25.11.2013, previously authorised to operate by the Municipality of Latiano by D.D. no. 1655 of 31.12.2004.
It holds UNI EN ISO 9001:2015 Quality Certification.





Simplified Floor Plan

It is an elegant house located right in the heart of the historic centre, next to the birthplace of Latiano's illustrious fellow citizen Blessed Bartolo Longo, Founder of the new Pompeii. It stands opposite the oldest building in Latiano, the Tower of Solise, and a short walk from the old Dominican convent.
The house is on two floors and is free of architectural barriers.
The facility's very central location fosters the residents' autonomy and socialisation.

Double bedrooms with en-suite bathroom	4
Bathrooms for the disabled	1
Dining room	1
Kitchen	1
TV room	1
Meeting room	1
Laundry	1

Furnishings and equipment

In order to meet the Guests' needs appropriately, the Community is furnished and equipped with all the comforts and features of a normal home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to ensure that the Community always functions properly.

Who it is for

The Group Home, i.e. a socio-rehabilitative residential facility with high-intensity care, with care cover 12 hours a day, from 8.00 to 20.00, accommodates 8 relatively autonomous users who have sufficiently acquired psychosocial skills.

Aims

The multi-professional and multidimensional management of the Community aims to tailor rehabilitation planning to each individual with mental distress, so that they can achieve the best possible level of mental, physical, social and emotional functioning. It promotes psychosocial skills in

relationships, social integration and re-entry, where possible, into the world of work, with a view to leaving the care/therapeutic/rehabilitation pathway.

The Rehabilitation Team

Work is organised according to the multidisciplinary team model: each member takes part in drawing up treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Medical Director, a psychiatrist, provides 6 hours per week of medical and psychiatric activity, scheduled according to the monthly calendar posted on the Community noticeboard. He supervises the staff and the Team in the rehabilitation of patients, works with GPs and specialists, and draws up the Therapeutic Plan on the basis of overall assessments of their mental and physical health.

- The Psychologist provides 6 hours per week of psychological activity, scheduled according to the monthly calendar posted on the Community noticeboard. She maintains relations with the Mental Health Services and works with them and with the staff in drawing up individual rehabilitation projects.

- The Coordination Manager, a senior healthcare professional, works during the day on weekdays, from Monday to Saturday, for a total of 36 hours per week, and is present at the facility for at least 6 hours a day. He or she is responsible for organising the Community and its staff, manages the facility's assets and the Guests' personal belongings, monitors the quality of the services provided, and oversees the management of the Guests' therapeutic and rehabilitation projects.

- The Healthcare Professionals (Social Workers, Psychiatric Rehabilitation Therapists, Professional Healthcare Educators and Nurses), 2 in number, ensure their presence over the 12-hour period, on the basis of monthly rotas covering day hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They observe and record individual and group behaviour and hold ongoing interviews with users in order to carry out rehabilitation interventions.

- The Social and Healthcare Workers (OSS), 2 in number, ensure their presence over the 12-hour period, again on the basis of monthly rotas covering day hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They provide domestic, care and hygiene/health services aimed at maintaining the Guests' functional autonomy.

The morning shift usually starts at 8:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 20:00.

In exceptional cases, times may vary by one hour at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest's therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.

- 1 Medical Director / Psychiatrist
- 1 Psychologist
- 1 Senior Healthcare Professional - Coordinator
- 2 Healthcare Professionals (Social Workers, Psychiatric Rehabilitation Therapists, Professional Healthcare Educators and Nurses)
- 2 OSS

In order to offer the Guests of the Group Home a higher-quality service, the staff includes the following additional members:

- 1 Administrative Manager;
- 1 Administrative Officer
- 1 Human Resources Manager

Community Life

Community life takes place both inside and outside the facility. Unless otherwise required for therapeutic reasons or for activity planning purposes, Community life is generally organised as follows:

07.00 Wake-up

07.30 Breakfast

8.30 – 9.30 Drug therapy

Care and cleaning of personal living space and common areas

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.30 Rehabilitation Workshops, activities and/or outings

19.00 Dinner and tidying of the dining room

Drug therapy

20.00 Free Time

Night rest

Rehabilitation

The multidisciplinary team provides care 12 hours a day.

Each Guest has an Individual Therapeutic Rehabilitation Plan (PTRI), drawn up by the Mental Health Centre (CSM). On the basis of this plan, the Community team sets the medium- and long-term goals to be achieved, in agreement with the Guest. If the referral comes directly from the Judicial Authority, the Team, starting from the prescriptions laid down, shares the case with the referring CSM, seeking the right balance between rehabilitation and supervision with a view to the patient's care and rehabilitation.

After an initial period of adjustment, the Guest must follow the therapeutic rehabilitation programme proposed to them, attending the workshops set out in their PTRI and taking part in the activities organised by the team (group outings with a therapeutic purpose, individual and group interviews, internal meetings); they must also take their medication regularly and show good treatment compliance.

Community Rules

Each Guest has their own private space, which they can personalise, and makes use of common areas in which to feel welcome and at ease.

All Guests are required to take care of themselves and their clothing: staff will point out any shortcomings and provide support where abilities are reduced.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open and Guests may go out at any time; however, outings are limited by participation in the Community's rehabilitation activities and/or by any therapeutic prescriptions issued by the Judicial Authority, the Mental Health Centre or the Community team. Generally, Guests may go out from 10.00 to 12.30 and from 16.30 to 18.30, after informing the staff on shift. Any exceptions will be dealt with by the Community team. Guests who are not clean and well groomed are advised not to go out.

The Community has a landline through which calls can be received and made, by prior arrangement with the facility staff. Guests have a personal telephone which they may use at set times agreed with the Community team or, if necessary, in the evening.

All Guests may receive visits from relatives and friends. However, such visits must not interfere with rehabilitation and work activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and the reception of visitors in certain areas should be mediated by a staff member, who will check beforehand that they are accessible.

Visits are generally possible from 10.00 to 12.00 and from 16.00 to 18.00. in some cases, visiting times and arrangements are governed by the therapeutic rehabilitation project and must be agreed with the Community team.

"CASA PER LA VITA" (HOME FOR LIFE) "GIOVANNI FALCONE"

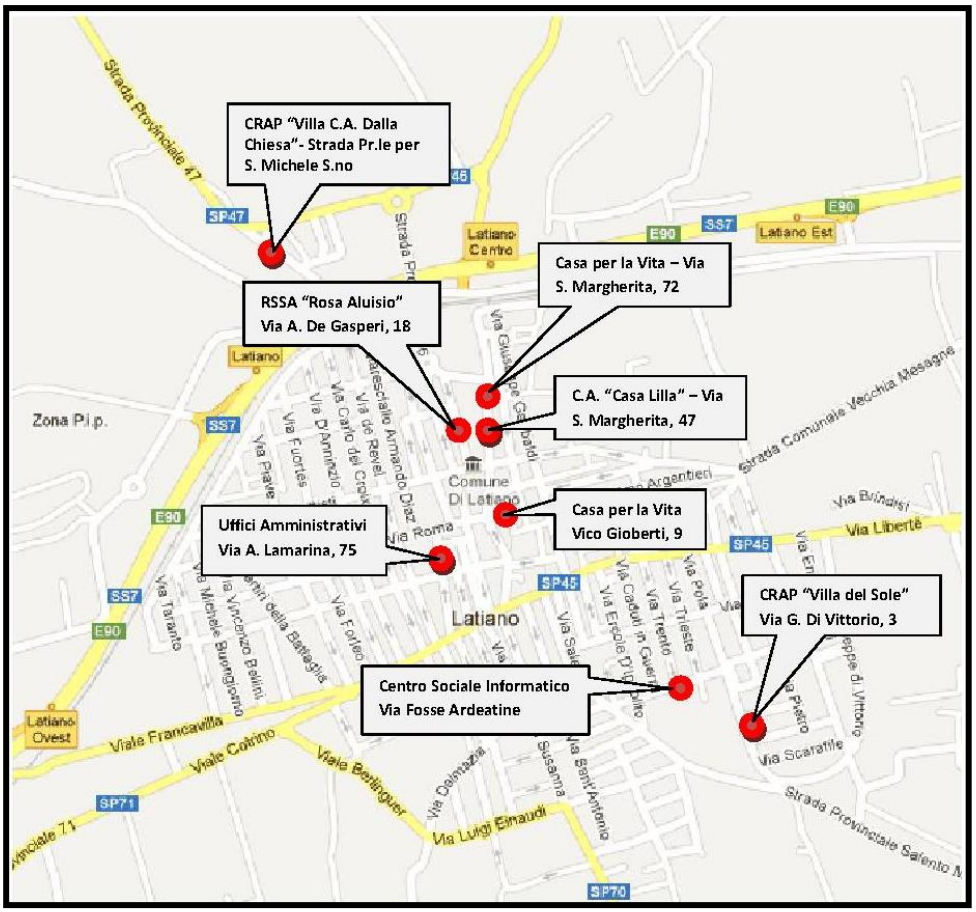
The facility

The "Casa per la Vita" "Giovanni Falcone" is located in Latiano (BR) at via Santa Margherita, no. 72, 2nd floor. The Coordination Manager is Dr. Francesca Mingolla, Social Worker.

Contact numbers: Community 0831 – 727744, Company mobile 3457512473.

Email: cpv@cittasolidale.net

Authorised to operate by the Municipality of Latiano by D.D. of the Social Services no. 582 of 29.07.2010, entered in the Regional Register under no. 0631 of 21.09.2010.
It holds UNI EN ISO 9001:2015 Quality Certification.



Simplified Floor Plan

The “Casa per la Vita” is housed in a private residential building and consists of two living units. It is located right in the heart of the historic centre, on the second floor, free of architectural barriers, surrounded by balconies and with spaces suitable for recreational and leisure activities.

Double bedrooms	2
Single bedrooms	2
Staff room	1
Bathrooms for Guests and the disabled	2
Staff bathrooms	1
Rooms for psychosocial activities	1
Dining room	1
Kitchen	2
TV room	1

Furnishings and equipment

In order to meet the Guests’ needs appropriately, the Community is furnished and equipped with all the comforts and features of a normal home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to ensure that the Community always functions properly.

Who it is for

The "Casa per la Vita" (Home for Life) is a social-healthcare residential facility with low-intensity healthcare assistance and 24-hour care coverage. It accommodates, on a temporary or permanent basis, people with psychosocial problems and stabilised psychiatric patients and/or those who need support in maintaining their level of autonomy and in their pathway of social and/or work integration or reintegration.

Aims

Its aim is to consolidate and maintain the level of autonomy, the capacities and the skills achieved, supporting the person in the process of social and/or work reintegration.

The Rehabilitation Team

Each member of the Team takes part in drawing up the treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Coordination Manager, in the person of a social worker, works during daytime hours on weekdays, from Monday to Saturday, for a total of 13 hours per week, with a presence at the facility of at least 2 hours per day. He/she is responsible for organising the Community and the staff, manages the structural and individual assets, monitors the quality of the services provided, and oversees the management of the Guests' therapeutic rehabilitation projects.

- The Social Worker and the Professional Educator ensure their presence over a 12-hour period, on the basis of monthly shift rotas covering daytime hours from Monday to Sunday, public holidays included. They observe and record individual and group behaviour and hold ongoing interviews with users for the implementation of rehabilitation interventions and group workshop activities.

- The Social-Healthcare Workers (OSS) ensure their presence over the entire 24-hour period, again on the basis of monthly shift rotas covering daytime and night-time hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They carry out domestic, care and hygiene/health-related tasks aimed at maintaining the functional autonomy of the Guests.

The morning shift usually starts at 8:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 21:00, while the night shift starts at 21:00 and ends at 8:00 the following day.
Times may also vary by one or two hours at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest’s therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.
At night, the presence of 1 social-healthcare worker will be scheduled.

- 1 Social Worker - Coordinator
- 1 Social Worker
- 1 Professional Educator
- 2 OSS

In order to offer the Guests of the "Casa per la Vita" a higher-quality service, a staff complement with the following additional units is guaranteed:

- 1 Administrative Manager;
- 1 Administrative Officer
- 1 Human Resources Manager

Community Life

Community life takes place both inside and outside the facility. Unless otherwise required for therapeutic reasons or for activity planning purposes, Community life is generally organised as follows:

7.00 Wake-up

07.30 – 07.45 Breakfast

Drug therapy

8.30 – 9.30 Care and cleaning of personal living space and common areas

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.30 Rehabilitation Workshops, activities and/or outings

19.00 Dinner and tidying of the dining room

Drug therapy

20.00 Free Time (TV, board games, etc.)

22.00 Night rest

Rehabilitation

The multidisciplinary team provides care 24 hours a day.

Each Guest has an Individual Care Plan (PAI), drawn up by the Multidimensional Assessment Unit (UVM). On the basis of this tool, the community team sets the medium- and long-term objectives to be achieved, in agreement with the Guest. After an initial period of adjustment, the Guest must follow the rehabilitation programme proposed to him/her, attending the workshops provided for in his/her PAI and taking part in the activities organised by the team (group outings with a therapeutic purpose, individual and group interviews, internal meetings); he/she must also take his/her medication regularly and show good therapeutic compliance.

The projects are implemented within the rehabilitation Workshops with the assistance of staff.

Community Rules

Each Guest has their own private space, which they can personalise, and makes use of common areas in which to feel welcome and at ease.

All Guests are required to take care of themselves and their clothing: staff will point out any shortcomings and provide support where abilities are reduced.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open and allows Guests to go out at any time; however, outings are limited by participation in the community's rehabilitation activities and/or by any therapeutic prescriptions of the Community team. Generally, outings may take place from 10.00 to 12.30 and from 16.30 to 18.30, informing the staff on duty in advance. Any exceptions will be dealt with by the community team. Going out is discouraged for Guests who have not attended to their personal hygiene and appearance.

The community has a landline that allows telephone calls to be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the community team.

All Guests may receive visits from relatives and friends. However, such visits must not interfere with rehabilitation and work activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and the reception of visitors in certain areas should be mediated by a staff member, who will check beforehand that they are accessible.

Visits are generally possible from 10.00 to 12.00 and from 16.00 to 18.00. in some cases, visiting times and arrangements are governed by the therapeutic rehabilitation project and must be agreed with the Community team.

CASA PER LA VITA “FRANCO BASAGLIA”

The facility

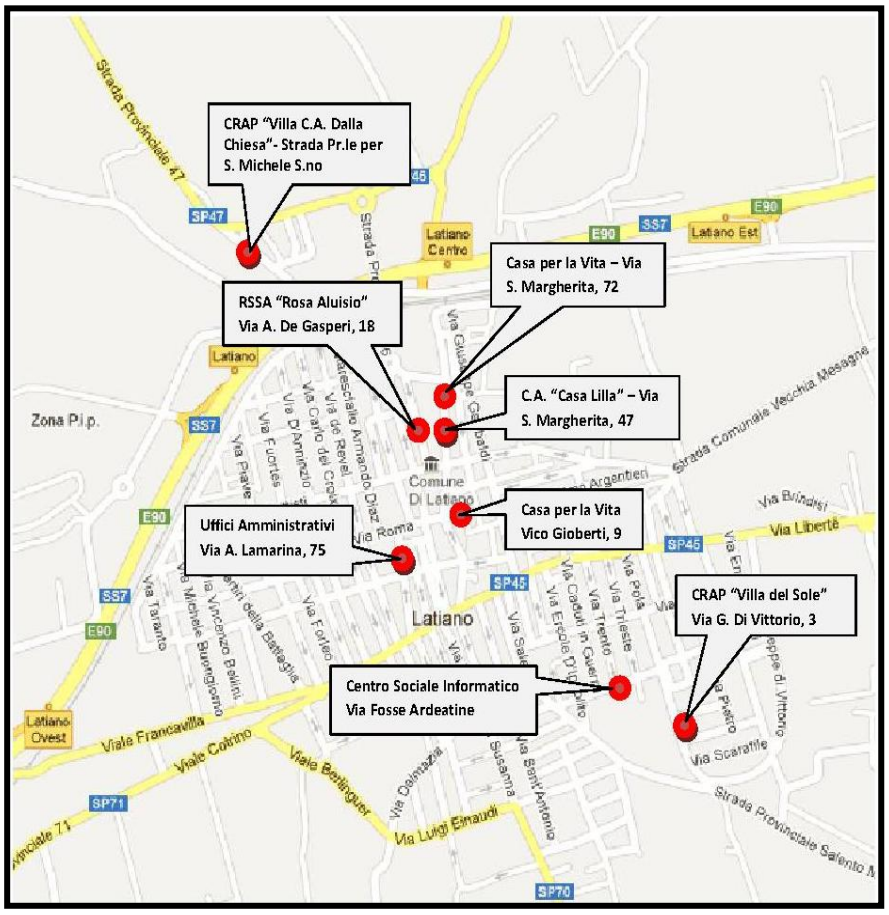
The "Casa per la Vita" “Franco Basaglia” is located in Latiano (BR) at vico Gioberti, n. 9. The Coordination Manager is Dr. Francesca Mingolla, Social Worker; the Healthcare Manager is Dr. Francesco Franza,

Psychiatrist; the Consultant Psychiatrist is Dr. Vincenzo Capozza; the Psychologist is Dr. Antonella Vacca, Psychotherapist.

Contact numbers: Community 0831 – 727744, Company mobile 3457512473.

Email: cpv@cittasolidale.net

Authorised to operate by the Municipality of Latiano with Social Services Executive Decision (D.D.) no. 779 of 19.09.2012, entered in the Regional Register under no. 1499 of 28.12.2012.
It holds UNI EN ISO 9001:2015 Quality Certification.



Simplified Floor Plan

The "Casa per la Vita" is located in a private dwelling. It is situated right in the historic centre, on the ground floor, free of architectural barriers, surrounded by balconies and with spaces suitable for recreational and leisure activities.

Double bedrooms	3
Single bedroom	1
Bathrooms for Guests and the disabled	2
Staff bathrooms	1
Dining room	1
Kitchen	1
TV room	1

Furnishings and equipment

In order to meet the Guests' needs appropriately, the Community is furnished and equipped with all the comforts and features of a normal home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to ensure that the Community always functions properly.

Who it is for

The "Casa per la Vita" (Home for Life) is a social-healthcare residential facility with medium-intensity healthcare assistance and 24-hour care coverage. It accommodates, on a temporary or permanent basis, people with psychosocial problems and stabilised psychiatric patients and/or those who need support in maintaining their level of autonomy and in their pathway of social and/or work integration or reintegration.

Aims

Its aim is to consolidate and maintain the level of autonomy, the capacities and the skills achieved, supporting the person in the process of social and/or work reintegration.

The Rehabilitation Team

Each member of the Team takes part in drawing up the treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Coordination Manager, in the person of a social worker, works during daytime hours on weekdays, from Monday to Saturday, for a total of 19 hours per week, with a presence at the facility of at least 3

hours per day. He/she is responsible for organising the Community and the staff, manages the structural and individual assets, monitors the quality of the services provided, and oversees the management of the Guests' therapeutic rehabilitation projects.

- The Social Worker and the Professional Educators ensure their presence over a 12-hour period, on the basis of monthly shift rotas covering daytime hours from Monday to Sunday, public holidays included. They observe and record individual and group behaviour and hold ongoing interviews with users for the implementation of rehabilitation interventions and group workshop activities.

- The Social-Healthcare Workers (OSS) ensure their presence over the entire 24-hour period, again on the basis of monthly shift rotas covering daytime and night-time hours from Monday to Sunday, public holidays included, for a total of 36 hours per week. They carry out domestic, care and hygiene/health-related tasks aimed at maintaining the functional autonomy of the Guests.

The morning shift usually starts at 8:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 21:00, while the night shift starts at 21:00 and ends at 8:00 the following day.
Times may also vary by one or two hours at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest’s therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.
At night, the presence of 1 social-healthcare worker will be scheduled.

- 1 Medical Director / Psychiatrist
- 1 Psychologist
- 1 Social Worker - Coordinator
- 2 Social Workers
- 2 Professional Educators
- 4 OSS

In order to offer the Guests of the "Casa per la Vita" a higher-quality service, a staff complement with the following additional units is guaranteed:

- 1 Administrative Manager;
- 1 Administrative Officer
- 1 Human Resources Manager

- 1 OSS

Community Life

Community life takes place both inside and outside the facility. Unless otherwise required for therapeutic reasons or for activity planning purposes, Community life is generally organised as follows:

7.00 Wake-up

07.30 – 07.45 Breakfast

Drug therapy

8.30 – 9.30 Care and cleaning of personal living space and common areas

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.30 Rehabilitation Workshops, activities and/or outings

19.00 Dinner and tidying of the dining room

Drug therapy

20.00 Free Time (TV, board games, etc.)

22.00 Night rest

Rehabilitation

The multidisciplinary team provides care 24 hours a day.

Each Guest has an Individual Care Plan (PAI), drawn up by the Multidimensional Assessment Unit (UVM). On the basis of this tool, the community team sets the medium- and long-term objectives to be achieved, in agreement with the Guest. After an initial period of adjustment, the Guest must follow the rehabilitation programme proposed to him/her, attending the workshops provided for in his/her PAI and taking part in the activities organised by the team (group outings with a therapeutic purpose,

individual and group interviews, internal meetings); he/she must also take his/her medication regularly and show good therapeutic compliance.

The projects are implemented within the rehabilitation Workshops with the assistance of staff.

Community Rules

Each Guest has their own private space, which they can personalise, and makes use of common areas in which to feel welcome and at ease.

All Guests are required to take care of themselves and their clothing: staff will point out any shortcomings and provide support where abilities are reduced.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open and allows Guests to go out at any time; however, outings are limited by participation in the community's rehabilitation activities and/or by any therapeutic prescriptions of the Community team. Generally, outings may take place from 10.00 to 12.30 and from 16.30 to 18.30, informing the staff on duty in advance. Any exceptions will be dealt with by the community team. Going out is discouraged for Guests who have not attended to their personal hygiene and appearance.

The community has a landline that allows telephone calls to be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the community team.

All Guests may receive visits from relatives and friends. However, such visits must not interfere with rehabilitation and work activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and the reception of visitors in certain areas should be mediated by a staff member, who will check beforehand that they are accessible.

Visits are generally possible from 10.00 to 12.00 and from 16.00 to 18.00. in some cases, visiting times and arrangements are governed by the therapeutic rehabilitation project and must be agreed with the Community team.

HEALTHCARE RESIDENTIAL FACILITY FOR THE ELDERLY (R.S.A.)

"ROSA ALUISIO"

The facility

The long-term care Healthcare Residential Facility for the elderly (RSA) is located in Latiano (BR) at via De Gasperi, n° 14-16, extension of via S. Margherita n. 47, ground floor.

The Coordination Manager is Dr. Roberta Fortunato Priore, Senior Healthcare Professional; the Healthcare Manager and Medical Specialist is Dr. Vincenzo Capozza, Neurologist/Psychiatrist; the Psychologist is Dr. Ivana Colizzi, Psychotherapist.

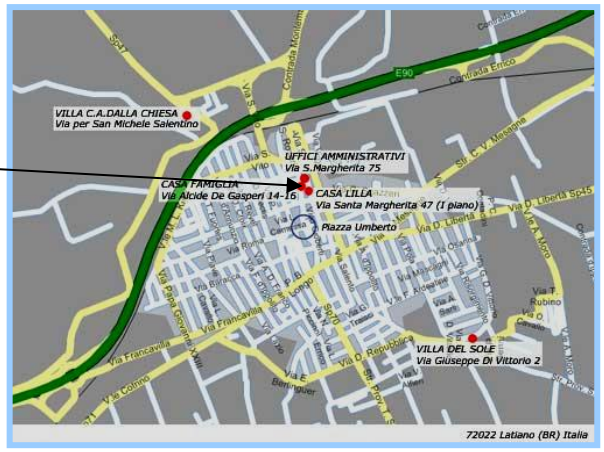
Contact numbers: Community 0831 – 721016, company mobile 3384343311.

Email: rssa@cittasolidale.net

Entered in the Regional Register under no. 0595 of 22.05.2012, authorised to operate by the Municipality of Latiano with Executive Decision (D.D.) no. 395 of 09.05.2012. The type A long-term care RSA for the Elderly “Rosa Aluisio” obtained accreditation with Executive Act no. 00303 of 23.10.2023 and is under contract with the ASL of Brindisi, ref. no. 20885 of 29.02.2024.

It holds UNI EN ISO 9001:2015 Quality Certification.





Simplified Floor Plan

The facility is built on two floors, free of architectural barriers, surrounded by balconies, windows and a garden, overlooking a central street of the town. It is located right in the historic centre, opposite the Town Hall, a short walk from the Post Office and the main square. It consists of three modules: the first has 10 beds, the second 8 beds and the third 6 beds.

The facility’s very central location fosters the residents’ autonomy and socialisation.

Double bedrooms with en-suite bathroom	12
Staff station with bathroom	1
Staff room with bathroom	2
Toilets for visitors and/or disabled people	3
Medical room with bathroom	1
Dining room	3
Kitchen	2
TV room	2

Room for pedagogical and educational activities	1
Gym (changing room and bathroom)	1
Men's/women's changing rooms with bathroom	2
Linen store	1
Mortuary	1
Inner garden	1

Furnishings and equipment

The Residence is furnished and equipped with all the comforts and features of a private home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to always ensure the proper functioning of the Community. The Residence has heating and air-conditioning systems. There are electric beds and hoists, pressure-relief mattresses and cushions, call/alarm systems, wheelchairs and other medical equipment.

Who it is for

To elderly people over 64 years of age with severe psychophysical impairments, as well as people suffering from senile dementia, who do not require complex healthcare services but do require a high level of personal care with assistance and social-rehabilitation interventions involving a high degree of social and healthcare integration, who are unable to lead an independent life and whose conditions, not in the acute phase, mean that they cannot be cared for at home. Exceptionally, for people suffering from senile dementia, Alzheimer's disease and related dementias, admission may take place without the age prerequisite.

Aims

The Residence aims to provide long-term care, functional recovery and maintenance, scheduled medical, nursing, psychological, personal and social care, delivering qualified social-healthcare services, socio-educational, rehabilitation, recreational and cultural interventions.

It promotes the maintenance and strengthening of residual capacities for independent living, stimulating interests and social relationships, and safeguarding the quality of life of the elderly or disabled person.

The Rehabilitation Team

Work is organised according to the multidisciplinary team model: each member takes part in drawing up treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Healthcare Manager, namely a medical specialist, oversees compliance with hygiene and health regulations, the correct application of the methodologies in use, the management of medicines and the recording of medical records, collaborates with GPs (MMG) and specialists, and supervises the staff and the Team in the rehabilitation of patients.

- The Medical Specialist in rehabilitation collaborates with the Team for the correct implementation of and compliance with the PAI.

- The Psychologist collaborates with the Team and the staff in drawing up the individual care/rehabilitation projects.

- The Social Worker handles the social secretariat and manages relations with families.

- The Coordination Manager, in the person of a registered nurse, guarantees his/her daily presence. He/she is responsible for organising the Community and the staff, manages the structural and individual assets and monitors the quality of the services provided.

- The Professional Educators observe and record individual and group behaviour, carrying out occupational and recreational activities and activities for integration with the environment and with the family of origin.

- The Nurses carry out the numerous healthcare services that the elderly need, administering medication, accompanying them to external specialist appointments, liaising with doctors and keeping the Healthcare Manager constantly informed.

- The Rehabilitation Therapist is responsible for the physiotherapy needs of the elderly, preserving their bodily functions.

- The Social-Healthcare Workers (OSS) carry out domestic, care and hygiene/health-related tasks aimed at maintaining the functional autonomy of the Guests.

- Cook and assistant cook.

The morning shift usually starts at 7:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 21:00, while the night shift starts at 21:00 and ends at 7:00 the following day.
Times may also vary by one or two hours at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest's therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.
Each daytime shift must guarantee the presence of at least 3 social-healthcare workers and 1 nurse. At night, the presence of at least 2 social-healthcare workers and 1 nurse will be scheduled.

- 1 Healthcare Manager;
- 1 Medical Specialist;
- 3 Registered Nurses;
- 1 Social Worker;
- 1 Psychologist;
- 1 Professional Educator;
- 1 Rehabilitation Therapist;
- 6 OSS - Social-Healthcare Workers;

In order to offer the Guests of the residence a more attentive and higher-quality service, a staff complement with the following additional units is guaranteed:

- 8 OSS - Social-Healthcare Workers;
- 1 Administrative Manager;
- 1 Administrative Officer
- 1 Human Resources Manager
- 1 Facility Coordinator - nurse;
- 2 Registered Nurses;
- 1 Cook;
- 1 Auxiliary.

Community Life

Community life is generally organised as follows, unless otherwise prescribed for therapeutic reasons or required for activity planning:

6.00 Wake-up

07.00 Breakfast

Drug therapy

8.30 – 9.30 Care and cleaning of personal living space and common areas

9.30 Mid-morning snack

10.00 – 12.00 Rehabilitation Workshops, outings and visits

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.00 Rehabilitation Workshops, activities and/or outings

18.30 Dinner and tidying of the dining room

Drug therapy

20.00 Night rest

Community Rules

The family and the person concerned must contact their family doctor and/or the Social Services of their municipality of residence, who certify the person's non-self-sufficiency and inability to remain at home. Following this, the competent Social-Healthcare District activates the UVM to take charge of the case and draw up the PAI, using the SVAMA assessment tool.

At the time of taking charge, this Service Charter and the Service Regulations are provided.

Each Guest has an Individual Care Plan (PAI); on the basis of this tool, the community team sets the medium- and long-term objectives to be achieved, in agreement with the Guest. After an initial period of adjustment, the Guest must follow the therapeutic programme proposed to him/her, taking part in the activities organised by the team; he/she must also take his/her medication regularly and show good therapeutic compliance.

Each Guest has their own private space, which they can personalise, and makes use of common areas in which to feel welcome and at ease.

All Guests are required to take care of themselves and their clothing: staff will point out any shortcomings and provide support where abilities are reduced.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open; generally, outings may take place from 10.00 to 12.30 and from 16.30 to 18.30, accompanied by the staff on duty.

The Community has a landline through which calls can be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the Community team.

All Guests may receive visits from relatives and friends. However, such visits must not hinder activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and access to certain areas should be mediated by a staff member, who will check their accessibility in advance.

Visits are allowed only from 10.00 to 12.00 and from 16.00 to 18.00; any exceptions must be agreed with the community team.

HEALTHCARE RESIDENTIAL FACILITY FOR DISABLED PEOPLE (RSA) “MYOSOTIS”

The facility

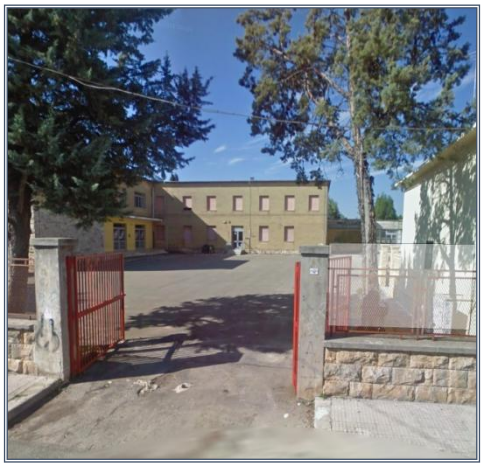
The type A and B long-term care Healthcare Residential Facility for disabled people (RSA) is located in Erchie (BR), via Duca degli Abruzzi. The Coordination Manager is Dr. Irene Passiatore, Professional Educator; the Healthcare Manager is Dr. Vincenzo Capozza - Neurologist/Psychiatrist.

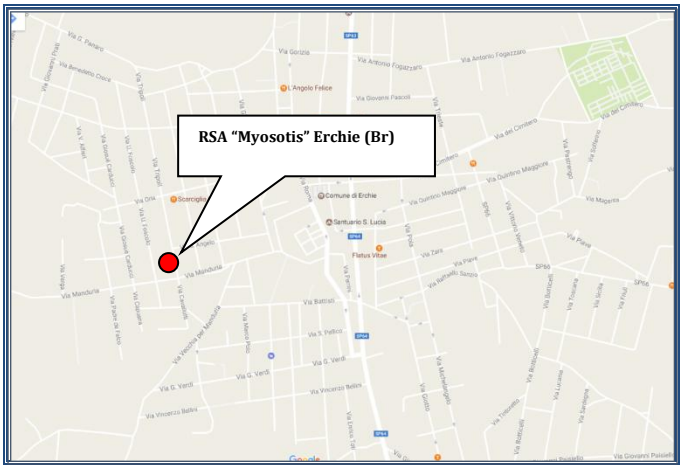
Contact numbers: Community 0831 – 767599, company mobile 3483964644.

Email: myosotis@cittasolidale.net

Entered in the Regional Register under no. 1094 of 24.11.2014, authorised to operate by the Municipality of Erchie with Executive Decision (D.D.) no. 246 of 24.07.2014. It meets the requirements for regional accreditation under RR 16/2019.

It holds UNI EN ISO 9001:2015 Quality Certification.





Simplified Floor Plan

The Social-Healthcare Residential Facility for Disabled People under R.R. 5/2019 (formerly a Social-Rehabilitation Community under art. 57 R.R. 4/2007) is located next to schools, social and sports centres and covers an area of 500 m², on the ground floor and first floor, free of architectural barriers.

Double bedrooms with en-suite bathroom		6
Single bedroom with en-suite bathroom		1
Staff room with bathroom	1	
Toilets for visitors and/or disabled people		3
Dining room	1	
Kitchen	1	
TV room	1	
Room for pedagogical and educational activities		1
Laundry	1	
Archive	1	
Inner garden	1	

Furnishings and equipment

To appropriately meet the needs of its Guests, the residence is furnished and equipped with every comfort. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to always ensure proper functioning.

Who it is for

The Residence accommodates people with stabilised physical, mental or sensory disabilities, aged between 18 and 64, who do not require complex healthcare services but do require a high level of personal care with social-rehabilitation interventions for the recovery and maintenance of residual functional abilities.

Aims

The stay is aimed at the clinical and functional maintenance of the Guests, with the objective of completing the recovery of the capacities, skills and knowledge destroyed by the illness and, consequently, their reintegration into society.

The Rehabilitation Team

Work is organised according to the multidisciplinary team model: each member takes part in drawing up treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Healthcare Manager, namely a medical specialist, oversees compliance with hygiene and health regulations, the correct application of the methodologies in use, the management of medicines and the recording of medical records, collaborates with GPs (MMG) and specialists, and supervises the staff and the Team in the rehabilitation of patients.

- The Coordination Manager, in the person of a professional educator, works during daytime hours on weekdays, from Monday to Saturday, for a total of 36 hours per week, with a presence at the facility of at least 6 hours per day. He/she is responsible for organising the Community and the staff, manages the structural and individual assets, monitors the quality of the services provided, and oversees the management of the Guests' therapeutic rehabilitation projects.

- The Social Worker handles the social secretariat and manages relations with families.

- The Professional Educator observes and records individual and group behaviour, carrying out occupational and recreational activities and activities for integration with the environment and with the family of origin.

- The Nurse carries out the numerous healthcare services, administering medication, accompanying Guests to external specialist appointments, liaising with doctors and keeping the Healthcare Manager constantly informed.

- The Physiotherapist is responsible for the physiotherapy area, preserving the person's bodily functions.

- The Social-Healthcare Workers (OSS) carry out domestic, care and hygiene/health-related tasks aimed at maintaining the functional autonomy of the Guests.

- Cook.

The morning shift usually starts at 8:00 and ends at 14:00. The afternoon shift starts at 14:00 and ends at 21:00, while the night shift starts at 21:00 and ends at 8:00 the following day.
Times may also vary by one or two hours at the start or end of the working shift, depending on the needs of the Community and, above all, on the Guest’s therapeutic and rehabilitation project. However, times are always planned according to the monthly rota drawn up by the coordinator.
Each daytime shift must guarantee the presence of at least 2 staff members. At night, 2 staff members are on duty (1 nurse, 1 OSS).

- 1 Healthcare Manager;
- 3 full-time Registered Nurses and 1 Registered Nurse for 24 hours per week;

- 1 Social Worker;
- 1 Professional Educator;
- 1 Rehabilitation Therapist;
- 4 Social-Healthcare Workers.

In order to offer the Guests of the residence a more attentive and higher-quality service, a staff complement with additional units is guaranteed:

- 1 Administrative Manager;
- 1 Facility Coordinator;
- 3 OSS;
- 1 Administrative Manager;
- 1 Administrative Officer
- 1 Human Resources Manager

Technological resources

In accordance with R.R. no. 5/2019, the following technological resources are available:

- 13 electric height-adjustable articulated beds with side rails and wheels (for all the residence's beds);
- 2 pressure-relief mattresses;
- 4 pressure-relief cushions;
- call/alarm system;
- electric patient hoist with slings;
- wheelchairs;
- aerosol therapy devices;
- 1 bronchial aspirator + 1 portable bronchial aspirator with rechargeable battery system;
- 2 shower chairs
- availability of medical gases.

Community Life

Community life takes place both inside and outside the facility. Unless otherwise required for therapeutic reasons or for activity planning purposes, Community life is generally organised as follows:

6.30 Wake-up

07.00 Breakfast

Pharmacotherapy

8.30 – 9.30 Care and cleaning of personal living space and common areas

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch and tidying of the dining room

13.30 Drug therapy

14.00 Afternoon rest

16.00 Snack

16.30 – 18.30 Rehabilitation Workshops, activities and/or outings

19.00 Dinner and tidying of the dining room

Drug therapy

20.00 Free Time (TV, board games, etc.)

22.00 Night rest

Rehabilitation

The multidisciplinary team provides care 24 hours a day.

Each Guest has an Individual Care Plan (PAI); on the basis of this tool, the community team sets the medium- and long-term objectives to be achieved, in agreement with the Guest.

After an initial settling-in period, the Guest must follow the rehabilitation programme proposed to them, attending the workshops set out in their PAI (Individual Care Plan) and taking part in the activities organised by the team (group outings with a therapeutic purpose, individual and group sessions, internal meetings); they must also take their medication regularly and show good therapeutic compliance.

Community Rules

The family and the person concerned must contact their family doctor and the Social Services of their municipality of residence, who certify the person's state of health (SVAMDi). Following this, the Social and Health District and the Municipality or the competent Territorial Area adopt any placement measures.

Each Guest has their own private space, which they may personalise, and makes use of common areas where they can feel welcome and at ease. All Guests are required to look after themselves and their clothing: staff will point out any shortcomings and will step in to support reduced abilities.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb the other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radio and television down. In particular, quiet must be respected during rest periods.

The facility is open and Guests may go out at any time; however, outings are limited by participation in the community's rehabilitation activities and/or by any therapeutic prescriptions of the Community team. Generally, outings may take place from 10.00 to 12.30 and from 16.30 to 18.30, accompanied by the staff on shift. Any exceptions will be dealt with by the community team. Going out is not advisable for Guests who are not clean and well groomed.

The community has a landline that allows telephone calls to be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the community team.

All Guests may receive visits from relatives and friends. However, such visits must not interfere with rehabilitation and work activities and must respect the privacy of the other Guests. For this reason, visits should be scheduled, and the reception of visitors in certain areas should be mediated by a staff member, who will check beforehand that they are accessible.

Visits are generally possible from 10.00 to 12.00 and from 16.00 to 18.00. in some cases, visiting times and arrangements are governed by the therapeutic rehabilitation project and must be agreed with the Community team.

SOCIO-EDUCATIONAL AND REHABILITATION DAY CENTRE FOR PEOPLE WITH DISABILITIES

"MYOSOTIS"

The facility

The Day Centre is located in the Healthcare Residential Facility (RSA) for people with disabilities in Erchie (BR), via Duca degli Abruzzi. The Coordination Manager is Dr. Irene Passiatore, Professional Educator; the Medical Director and Specialist Physician is Dr. Vincenzo Capozza, Neurologist/Psychiatrist.

Contact numbers: Community 0831 – 767599, company mobile 3483964644.

Email: myosotis@cittasolidale.net

Entered in the Regional Register no. 161 of 26.02.2018, authorised to operate by the Municipality of Erchie with Executive Decision (D.D.) no. 21 of 16.01.2018. The Day Centre for People with Disabilities obtained accreditation by Executive Act no. 00120 of 26.03.2024 and holds a contract with the ASL of Brindisi, ref. no. 36267 of 16.04.2024.

It holds UNI EN ISO 9001:2015 Quality Certification.

Simplified Floor Plan

The Residence is located next to schools, social and sports centres and covers an area of approximately 200 m², on the ground floor, free of architectural barriers.

Bedrooms for day use	1	
Toilets for visitors and/or disabled people		3
Dining room		1
Kitchen		1
Educational activities room	1	
Gym	1	
Laundry		1
Archive		1
Inner garden		1

Furnishings and equipment

To meet the Guests' needs appropriately, the Centre is furnished and equipped with all the comforts and features of a private home. All rooms are bright, well furnished and made welcoming with decorative touches, including personal ones. The furnishings and the entire facility are carefully maintained so as to ensure that everything always works properly.

Who it is for

The Day Centre welcomes people with stabilised physical, mental and sensory disabilities, with significant impairment of functional autonomy, who require rehabilitation services of a social and healthcare nature.

Aims

Its aim is to maintain the person's residual functional abilities and levels of autonomy, while supporting the family.

It adopts individual rehabilitation planning, through a wide range of sheltered recreational and socialisation workshops, expressive, psychomotor and play activities, cultural and training activities, and social and healthcare rehabilitation services.

The Rehabilitation Team

Work is organised according to the multidisciplinary team model: each member takes part in drawing up treatment plans and assesses their progress during periodic meetings held at least every 15 days.

- The Medical Director supervises the staff and the Team in the rehabilitation of patients, works with GPs and specialists, and draws up the Therapeutic Plan on the basis of comprehensive assessments of their psychophysical health.

- The Medical Specialist in rehabilitation collaborates with the Team for the correct implementation of and compliance with the PAI.

- The Coordination Manager, a professional educator, is responsible for organising the centre and the staff, manages structural and individual assets, oversees the quality of the services provided, and supervises the management of the Guests' therapeutic projects.

- The Psychologist collaborates with the Team and the staff in drawing up the individual care/rehabilitation projects.

- The Social Worker handles the social secretariat and manages relations with families.

- The Professional Educator observes and records individual and group behaviour, carrying out occupational and recreational activities and activities for integration with the environment and with the family of origin.

- The Physiotherapist is responsible for the physiotherapy area, preserving the person's bodily functions.

- The Social and Healthcare Worker (OSS) provides domestic, care and hygiene/health services aimed at maintaining functional autonomy.

- 1 Medical Director
- 1 Specialist Physician
- 1 Psychologist
- 1 Professional Educator
- 1 Rehabilitation Therapist
- 1 Social Worker
- 1 OSS

Life at the Centre

The Centre plans its activities, varying them according to the needs of those attending, eight hours a day, 6 days a week. The activities, which are open to the local area, are organised by drawing on the resources of the local Community.

Life at the Centre takes place both indoors and outdoors. Generally, unless otherwise directed for therapeutic reasons and subject to activity scheduling needs, Community life is organised as follows:

9.00 Activities begin

9.30 Snack

"Meet up" (daily meeting of the Guest group with the staff on shift)

10.00 – 12.00 Rehabilitation Workshops (according to a weekly schedule)

12.30 Lunch

13.30 Drug therapy

14.00 Relaxation and/or individual activities

15.30 Afternoon snack

16.00 – 17.00 Rehabilitation workshops, activities and/or outings

17.00 Return home

Rehabilitation

Each Guest has an Individual Care Plan (PAI); on the basis of this tool, the team sets the medium- and long-term objectives to be achieved, in agreement with the Guest. The Guest must follow the rehabilitation programme proposed to them, attending the workshops set out in their PAI and taking part in the activities organised by the team (group outings with a therapeutic purpose, individual and family sessions, internal meetings); they must also take their medication regularly and show good therapeutic compliance.

Community Rules

The family and the person concerned must contact their family doctor and the Social Services of their municipality of residence, who certify the person's lack of self-sufficiency and inability to continue living at home. Following this, the Social and Health District and the Municipality or the competent Territorial Area adopt any placement measures and take charge of the admission fee.

Each Guest has their own private space and makes use of common areas where they can feel welcome and at ease.

The Guest is required to look after themselves and their clothing: staff will point out any shortcomings and will step in to support reduced abilities.

Cleaning and tidiness of the facility are ensured by the staff on duty; Guests are actively involved in

carrying out daily activities in order to maintain and improve their level of autonomy.

So as not to disturb other Guests, everyone is required to avoid noise, not to shout and to keep the volume of radios and televisions down.

The facility is open and Guests may go out at any time with the staff on shift; however, outings are limited by participation in rehabilitation activities and/or by any therapeutic prescriptions of the Centre's team. Going out is not advisable for Guests who are not clean and well groomed.

The Community has a landline through which calls can be received and made, by prior arrangement with the facility staff. Guests who have a personal telephone may use it at set times agreed with the Community team.

FEES

The reference fees for residential and semi-residential services provided by Città Solidale's facilities, relating to Healthcare and Social-Healthcare Assistance for non-self-sufficient persons, people with disabilities and people with mental disorders, are set by the Regional Government and periodically reviewed. At the date of drafting this Document, the fees, including their breakdown, are as summarised in the following table:

FEE TABLE					**CO-PAYMENT SHARES**			
CARE SETTING	**LEGISLATION**	**TYPE OF FACILITY**	**PLACES**	**FEE in euros per user/per day**	**Share paid by the SSR (Regional Health Service) in euros**		**Share paid by USER/MUNICIPALITY in euros**	
MENTAL HEALTH	R.R. 3/2005 R.R. 7/2002	INTENSIVE CRAP	14 beds	202,38	100%			
		GROUP HOME	8 beds	136,45	100%			
DISABILITY	R.R 5/2019	RSA SEVERE	6 beds	108,37	70%		30%	32,51
		RSA LESS SEVERE	7 beds	84,79	40%		60%	50,87
		DAY CENTRE	3 places	77,35	70%		30%	23,21
NON-SELF-SUFFICIENT	R.R. 4/2019	RSA LONG-TERM CARE FOR THE ELDERLY	24 beds	100,33	50%	50,17	50%	50,17
MENTAL HEALTH / DISABILITY	R.R. 4/2007	CASA PER LA VITA MEDIUM INTENSITY	7 beds	109,47	70%	76,63	30%	32,84
		CASA PER LA VITA LOW INTENSITY	6 beds	69,31	40%	27,72	60%	41,58

MANAGEMENT CONTROL

MANAGEMENT AND COORDINATION SYSTEMS

Residential services are distinctive services that involve forms of organised living together and are called upon to combine, in everyday life, dimensions of subjectivity, community and organisation.

Residential services must therefore provide continuity in managing health problems, whether related to acute conditions, chronic conditions or lack of self-sufficiency, while at the same time ensuring for each Guest continuity in their relationship with their own history, with their wealth of experience and identity, and with their family and personal bonds and affections.

Therefore, healthcare and care skills and professionalism must be combined with the ability to pay attention to the organisational dimensions of the service, that is, to the quality of work processes and of the ways of interacting with and recognising those who work there, those who come into contact with it, those who entrust themselves to it and those who entrust others to it.

It is therefore essential that the organisation invests in building the “object of work” so as to be able to represent the service it intends to provide, namely the points of reference to be kept in the relationship with Guests and their families, and the values and scientific hypotheses that guide it.

Indeed, in the actions of staff, their “internal” mental and emotional representations, their sensitivities and their values are central.

If the object of work is not sufficiently defined, represented and related to work processes within which individuals can “see” themselves, each person's work contribution easily tends towards fragmented logics and objectives, with the risk that they conflict with one another and that the points of reference become mainly those of the tasks in themselves. In the absence of a visible and shared object of work, internalised, implicit and often unconscious cultural models also tend to emerge. Thus each profession will follow its own codes and points of reference, giving rise to a more “institutionalising” and “mechanistic” work logic anchored to compliance with its own job description.

An organisation of this kind inevitably tends to reduce Guests and their family members to objects of interventions and care actions which may even be of high quality, but which fail to recognise their subjectivity. In this pattern, everyday minor conflicts between staff and Guests and their families also increase.

COORDINATION AS A RESOURCE

Coordination is a vital organisational function for the operation of any organisation, but it is also a specific responsibility assigned to certain roles.

The coordination function, in relation to the complexity, culture and management philosophy of the cooperative, is performed by different professional figures, with diversified content.

There are “central” coordination roles and others that are more “decentralised” at care unit level; in certain situations “collaborations” in coordination are introduced, and in others unit or shift “leads” are provided for.

Coordinators are required to perform various functions, both general, to ensure the coordination of the facilities, and micro-organisational: planning and at the same time day-to-day management of unforeseen events; monitoring general aspects of how the service is running, but also specific day-to-day operational behaviour of staff; managing relations with families in the initial phases of admission to the facility, but also intervening daily in minor conflicts between staff or with families.

Ensuring the general work context

One of their tasks is certainly to ensure the general work context, that is, maintaining and linking the general conditions that frame the work of staff and day-to-day operations: a very important task in organisations with many variables at play, such as our facilities. More specifically, this involves investing in harmonising the timing of the various internal services, ensuring supplies, maintaining overall work scheduling, ensuring compliance with rehabilitation and care standards, and maintaining staff cover in relation to absences, leave, holidays or unforeseen requirements in the Guests' care workloads.

Supporting the work of staff

Among the functions of coordinators is supporting and monitoring staff, an important and far from simple task. For this very reason, it is useful to analyse schematically some ways of exercising this function.

In this context, monitoring is associated with support, in the sense that monitoring is not understood as something external and normative but as something that interacts with work processes in order to keep them aligned with guidelines, objects of work and expected results. This involves:

- Monitoring and support through direct supervision
- Monitoring and support through procedures

- Monitoring and support through defining and nurturing the premises

Monitoring and support through direct supervision

This takes place by intervening directly with staff and their operations, correcting, supplementing and supporting. This approach is usually used in simple organisations with close operational relationships, at unit or service level, or when facing complex tasks that require close observation, particular technical skills and greater professional resources relative to the set of problems being addressed, or where staff skills are perceived to be weak.

In large group situations, this approach risks becoming costly if it is used to address recurring problems; it ends up dissipating organisational resources and does not necessarily allow the build-up of organisational learning that would subsequently reduce the need for it.

Monitoring and support through procedures

The Cooperative has obtained, and periodically renews, ISO 9001:2015 Quality Certification. This is achieved by building, updating and checking procedures, checklists, reference notes and forms, which aim to facilitate work and to avoid oversights, omitted actions and failure to check certain key points in carrying out tasks. They encourage attention to matters that would otherwise risk being set aside (for example, steps to be taken towards the Guest, family members and others). We are referring here to procedures drawn up by management and implemented by coordinators for their own area of coordination, often through the involvement of working groups.

These procedures are therefore of a different level from more general organisational ones, such as those linked to institutional quality certification (accreditation) or to more general organisational guidelines and regulations.

While procedures guide and support work behaviour, avoiding oversights and making it possible to trace who has carried out or omitted certain operations, they carry the potential risk of creating distance from the personal needs expressed by Guests and may reduce the sense of responsibility for more subjective and personalised commitment.

Wherever possible, involving staff in drawing up procedures helps them feel they have a part in determining working methods.

Monitoring and support through the premises

This is exercised by encouraging the recognition and sharing of technical and cultural "criteria" and "points of reference" that can support more focused, responsible and professional behaviour on the part of staff. With this approach, monitoring tends to shift from something "external", as when it is exercised through direct supervision or the definition of procedures, to something more internal, which also belongs to the staff member because their direct and proactive involvement is encouraged.

In this situation, staff are encouraged to invest more cognitively and emotionally in recognising their professional competence and knowledge, and trust and self-control are fostered. Its exercise and development are based on relational investment with staff, focusing on recognising and reworking aspects of the work, errors, problems and incidents, and new tasks to be tackled.

It requires investment of time and defined spaces for discussion, but it yields returns in terms of staff awareness and actions more oriented towards values and objectives, and it fosters greater job satisfaction. It is particularly important to develop this approach in situations where staff are asked to assess the various variables at play in order to introduce flexible and personalised work behaviour, guided by criteria rather than by predefined rules and standard behaviour.

Coordination and synergies between the roles and areas of the facility are ensured by a number of professional and operational integration bodies, namely:

- *Steering Committee* attended by the Director, the Rehabilitation Workshops Manager, the Medical Director and the facility Coordinator; its purpose is to ensure a unified and consistent approach to, and management of, activities and resources with respect to the results to be achieved as a service and the processes to be followed. Its purpose is to analyse, assess and address the organisational and management problems and changes needed for care that is always in line with demand and with the facility's efficiency requirements; it meets once every 2 months and/or whenever necessary.

- *Unit meetings* attended by the Activities Coordinator, the Medical Director and/or the Specialist Physician (psychiatrist), the rehabilitation/care staff (OSS and healthcare professional assistants), the Physiotherapist, the Professional Educator, the Social Worker

and the Psychologist; their purpose is to implement a rehabilitation/care and operational model for the service geared to the qualitative development of activities and staff, strongly integrated across its different professional components, and systematically and organically adjusted on the basis of the care and efficiency results achieved. Their purpose is to analyse, assess and address problems and changes in the Guests' needs. They meet once a week.

- *Daily handover meetings*: for healthcare activities, attended by the staff on duty at the facility.

The General Management of the Città Solidale Cooperative is responsible for identifying the necessary resources, taking into account training needs, the management, execution and checking of work activities, and internal audits.
The General Management of the Città Solidale Cooperative has made available the resources needed to implement and improve company processes in order to achieve the objectives of continuous improvement and stakeholder satisfaction.

HUMAN RESOURCES

Within the scope of its current and development objectives, the General Management has identified the skills needed to achieve the set results.
In particular:

- entry requirements, selection methods and continuing training have been defined;
- responsibilities and authority for operational activities are defined;
- individual and group objectives have been identified, and their results assessed;
- the necessary training for such activities has been arranged;
- the effectiveness of the training has been assessed.

The General Management considers continuing training an essential tool for the professional growth of its employees and collaborators and for the constant improvement of the quality of the services

provided. Criteria and methods have been defined for identifying employees' education and training needs. All training activity is duly recorded.

In view of the impact it may have on performance, the General Management pays particular attention to:

- effective horizontal and vertical communication;
- assignment of clear and well-defined tasks;
- involvement of staff in all activities;
- management and maintenance of infrastructure and equipment;
- defining and informing employees about safety and the use of personal protective equipment;
- use of information technology to facilitate production activities;
- involvement of all staff so that they are aware of the importance of their activities.

ECONOMIC RESOURCES

The objective of the General Management is to optimise and constantly improve the financial management of the Città Solidale Cooperative, so that:

- the company can deliver the established levels of quality and efficiency;
- development and growth are financed through the operating results.

Financial resources are managed through:

- annual definition of budgets;
- management control;
- periodic review of budget forecasts and actual figures.

The financial statements used in accounting are the following:

- financial accounting;
- cost (analytical) accounting;
- budget management accounting (budget forecast).

Each year the explanatory notes are prepared and attached to the final income statement, setting out:

- the criteria applied in valuing the financial statement items,
- changes in the asset and liability items of the balance sheet;
- composition and detailed description of the financial statement items,
- any observations on improvement actions and future objectives.

Particular attention is paid to monitoring activities, in order to prevent or correct any malfunction that might give rise to unnecessary and avoidable costs.

QUALITY AND TRAINING MANAGER

The Quality and Training Manager is a staff position reporting to the Management and performs their duties – in accordance with the Director's guidelines – for the benefit of all facilities. To this end, they oversee the areas described below.

Quality:

Supports the Director in defining and implementing the policies and development plans of the company quality system, in maintaining and verifying the requirements for the accreditation of services, and in the ongoing review and improvement of the quality levels achieved.

To this end, coordinates the drafting of the annual Plan of development objectives for the quality system

and the constant updating of the Service Charter.

Supports – in line with the Director's guidelines – the professionals involved in defining and reviewing the Facility and Unit Plans, according to a continuous improvement approach, and in drafting and updating the guidelines, protocols and operating procedures required by the quality system and by the accreditation requirements in force.

Oversees and ensures the design and implementation of tools and processes for assessing the satisfaction of Guests and their families, in order to promote constant evaluation and improvement of services and of the quality of life in the facilities.

Ensures or oversees the production and collection of the documentation required by the quality and accreditation system at the various levels; oversees the correct and efficient organisation of the related documentation and filing system, making use of the available technologies and liaising with the functions responsible for the company information system.

Training:

Oversees, with the input of the Director, the process of gathering and analysing training needs at the various levels of the organisation.

Drafts – on the basis of the needs analysis and in dialogue with the managerial functions – the annual Training Plan and submits it to the senior position (Director in Charge) for validation.

Ensures the delivery of the planned training initiatives, their monitoring and their evaluation, both in terms of learning outcomes and of participant satisfaction and impact within the company.

Maintains the documentation and certificates relating to the training activities carried out and to the achievement of training credits.

Promotes – with the cooperation of the managerial functions – opportunities for reflection and actions to improve the quality of training in relation to staff development needs, linked to the assistance, care and socialisation needs of the Guests.

ADMINISTRATIVE OFFICE

Position title: Administrative staff

Reports to: General Director

Performs the duties relating to the Accounting - stores and supplies - purchasing - reception - secretarial Service

Accounting

Ensures correct and timely compliance with accounting regulations and tax laws.

Is responsible for the regular and correct issuing of payment orders and collection orders, the issuing of invoices and other debit notes, the settlement of expenses and salaries, and the preparation and submission, in collaboration with the Accountant and/or the Labour Consultant and within the legal deadlines, of income tax returns, VAT returns and social security contribution returns.

Is responsible for recording accounting entries such as customer and supplier VAT registers, the general journal and the cash book.

Is also responsible for the periodic monitoring of outstanding receivables not yet collected and for promptly reporting any defaults to the Management; proposes the issuing of payment reminders, formal notices of default, debit notes and payment injunctions.

Carries out preparatory work by drafting measures concerning the accounting management of the Organisation.

Attends periodic meetings with the General Director, the Accountant and the Statutory Auditor to jointly examine the various issues relating to accounting management.

Stores, Supplies and Purchasing

Is responsible for the stores and supplies service and for the management of direct expenditure. Within these competences, the role covers:

- purchasing consumables in accordance with the supply contracts entered into by the Management;
- checking the proper performance of supply contracts;
- checking invoices;
- general control of the quality and quantity of goods and of their proper storage;
- necessary minor and urgent expenses;
- handling special collections and safekeeping of Guests' funds;
- drawing up and updating the Organisation's inventories;
- overseeing the routine maintenance of movable and immovable property, as well as of technical systems;
- Works with the Management, also putting forward proposals and measures to improve the management of stores and supplies and the other services under their supervision.
- Works with the other professional figures to ensure adequate coordination of interventions for the user.
- Attends periodic meetings with the Director and the other Managers to jointly examine the various issues relating to the management of the cooperative.

Reception and Secretarial Office

Handles the administrative and bureaucratic paperwork of the Guests of the various facilities.

Acts as an interface between the cooperative and the outside world, capable of representing it whenever it deals with the public, whether by telephone or in person, with courtesy and professionalism

Acts as a point of reference for the passing of information within the cooperative, a hub of information flows.

The duties are:

- managing the switchboard;
- providing information on admission procedures for the residential and semi-residential facilities.
- attendance and reception hours of managerial staff (director, coordinator of the rehabilitation workshops).
- service hours of the R.S.A.
- managing suppliers, notifying their arrival to the relevant person;
- receiving incoming mail and sorting and distributing it to the recipients;
- handling the delivery of messages to and from staff;
- keeping the Guests' attendance register, recording temporary absences;
- email and photocopying;
- safekeeping of keys.

The General Management sources and organises the resources and means needed to achieve the quality objectives.

The General Management, in view of the Regional Regulations, defines staffing requirements:

in numerical terms;

by functional position;

by qualification;

in relation to the volumes and types of activity.

QUALITY CERTIFICATIONS

The Social Cooperative "Città Solidale" has established and maintains an active Quality Management System compliant with the UNI EN ISO 9001:2015 Standard, as a means of ensuring that its services are managed and controlled with regard to quality and meet the standard.

Città Solidale obtained its first certification on 21.01.2013 from the body CISQ- RINA – IQNet The International Certification Network, accredited by Accredia (the Italian National Accreditation Body for Certification Bodies), with certificate no. 28510/13/S.

The validity of the certificate is subject to annual periodic surveillance and to a full review of the management system every three years.

Città Solidale has obtained certification for **all** its local units, namely:

- Administrative Offices
- Psychiatric Residential Care Community (C.R.A.P.) "Villa del Sole"
- Psychiatric Residential Care Community (C.R.A.P.) "Villa Carlo Alberto Dalla Chiesa"
- Psychiatric Group Home "Casa Lilla"
- RSA for the Elderly "Rosa Aluisio"
- RSA for the Disabled "Myosotis"
- Day Centre "Myosotis"
- "Casa per la Vita" (Home for Life) "Giovanni Falcone", low care intensity
- "Casa per la Vita" (Home for Life) "Franco Basaglia", medium care intensity

The main activities for which the Cooperative is certified are:

- Design and delivery of therapeutic and psychosocial rehabilitation services for people with psychiatric disorders;
- Design and delivery of care services for non-self-sufficient elderly and disabled people;

The Cooperative "Città Solidale" constantly monitors the effectiveness and efficiency of its processes (primary, management and support) in pursuing its policies and objectives, so as to respond to the growing needs and expectations of its guests and commissioning bodies and to ensure the dynamic evolution of its Quality Management System.

Quality objectives are set every year, on the basis of the needs of the organisation and of the needs of guests and commissioning bodies. The management of the Social Cooperative "Città Solidale" periodically verifies, approves, monitors and reviews the quality objectives.

The activities provided for by the Quality System essentially aim to achieve:

- Constant satisfaction of the user and of the referring service

- The optimisation and improvement of the service offered
- The continuous pursuit of efficiency and effectiveness in its organisational structure.

The Cooperative considers the active and effective participation of all staff in maintaining and implementing the Quality System to be of fundamental importance; it has therefore taken steps to raise adequate awareness among its human resources, widely disseminating the aims and objectives of the Quality Policy, and it also considers it a duty that all organisational functions adhere rigorously and precisely to the provisions of the Quality System documentation while at the same time contributing to its constant improvement.

CISQ is a member of

IQNET
The International Certification Network
www.iqnet-certification.com

CERTIFICATO N. 28510/13/S
CERTIFICATE No.

Per informazioni sulla validità del certificato, visitare il sito www.rina.org

For information concerning validity of the certificate, you can visit the site www.rina.org

SI CERTIFICA CHE IL SISTEMA DI GESTIONE PER LA QUALITÀ DI
IT IS HEREBY CERTIFIED THAT THE QUALITY MANAGEMENT SYSTEM OF

CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE

VIA ANANIA LAMARINA, 75 72022 LATIANO (BR) ITALIA

NELLE SEGUENTI UNITÀ OPERATIVE */ IN THE FOLLOWING OPERATIONAL UNITS*

VIA ANANIA LAMARINA, 75 72022 Latiano (BR) ITALIA
VEDI ALLEGATI

E UNITÀ OPERATIVE INDICATE NELLE PAGINE SUCCESSIVE */ AND OPERATIONAL UNITS IN THE FOLLOWING PAGES*

È CONFORME ALLA NORMA */ IS IN COMPLIANCE WITH THE STANDARD*

ISO 9001:2015

Per i requisiti della norma non applicabili al campo di applicazione del sistema di gestione dell'organizzazione, riferirsi alle informazioni documentate relative.

Reference is to be made to the relevant documented information for the requirements of the standard that cannot be applied to the Organization's management system scope

PER I SEGUENTI CAMPI DI ATTIVITÀ / *FOR THE FOLLOWING FIELD(S) OF ACTIVITIES*

PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI RIABILITAZIONE TERAPEUTICA E PSICOSOCIALE PER PERSONE CON DISTURBI PSICHIATRICI. PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI ASSISTENZA PER ANZIANI E DISABILI NON AUTOSUFFICIENTI.

IAF:38

DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.
DESIGN AND PROVISION OF ASSISTANCE SERVICES FOR ELDERLY AND DISABLED NON SELF-SUFFICIENT PEOPLE.

La validità del presente certificato è subordinata a sorveglianza periodica annuale / semestrale ed al riesame completo del sistema di gestione con periodicità triennale
The validity of this certificate is dependent on an annual / six monthly audit and on a complete review, every three years, of the management system
L'uso e la validità del presente certificato sono soggetti al rispetto del documento RINA: Regolamento per la Certificazione di Sistemi di Gestione per la Qualità
The use and validity of this certificate are subject to compliance with the RINA document: Rules for the certification of Quality Management Systems

Prima emissione *First issue*	21.01.2013	Data decisione di rinnovo *Renewal decision date*	30.10.2024
Data scadenza *Expiry Date*	02.11.2027	Data revisione *Revision date*	30.10.2024

Marcello Manno
Taranto Management System Certification, Head

RINA Services S.p.A.
Via Corsica 12 - 16128 Genova Italy

ACCREDIA
SGQ N° 002 A
Membro degli Accordi di Mutuo Riconoscimento EA, IAF e ILAC
Signatory of EA, IAF and ILAC Mutual Recognition Agreements

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CERTIFICATO N. / CERTIFICATE No. 28510/13/S

Altre unità operative coperte dal sistema di gestione di:
Other operational units covered by the management system of:

Per informazioni sulla validità del certificato, visitare il sito www.rina.org
For information concerning validity of the certificate, you can visit the site www.rina.org

CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE

Organizzazione operante secondo le prescrizioni del sistema di Gestione conforme alla Norma /
Organization operating in accordance with the requirements of the Management System standard

ISO 9001:2015

Unità Operative/Operational units (Ragione sociale-Indirizzo Sito / Registered name - Site address)	Campi di attività specifiche / Specific field(s) of activities
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE CASA PER LA VITA "F. BASAGLIA" - Assistenza e riabilitazione psicosociale VICO GIOBERTI, 9 72022 LATIANO (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI RIABILITAZIONE TERAPEUTICA E PSICOSOCIALE PER PERSONE CON DISTURBI PSICHIATRICI. DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE CASA PER LA VITA "G. FALCONE" - Assistenza e riabilitazione psicosociale VIA SANTA MARGHERITA, 72 72022 LATIANO (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI RIABILITAZIONE TERAPEUTICA E PSICOSOCIALE PER PERSONE CON DISTURBI PSICHIATRICI. DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE COMUNITA' ALLOGGIO "CASA LILLA" - Assistenza e riabilitazione psichiatrica VIA S. MARGHERITA, 47/I 72022 LATIANO (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI RIABILITAZIONE TERAPEUTICA E PSICOSOCIALE PER PERSONE CON DISTURBI PSICHIATRICI. DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE C.R.A.P. "VILLA CARLO ALBERTO DALLA CHIESA" - Comunità riabilitativa assistenziale psichiatrica S.P. SAN MICHELE SALENTINO 72022 LATIANO (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI RIABILITAZIONE TERAPEUTICA E PSICOSOCIALE PER PERSONE CON DISTURBI PSICHIATRICI. DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE C.R.A.P. "VILLA DEL SOLE" - Comunità riabilitativa assistenziale psichiatrica VIA G. DI VITTORIO, 3 72022 LATIANO (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI RIABILITAZIONE TERAPEUTICA E PSICOSOCIALE PER PERSONE CON DISTURBI PSICHIATRICI. DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.

Data revisione
Revision date 30.10.2024

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Organizzazione operante secondo le prescrizioni del sistema di Gestione conforme alla Norma /
Organization operating in accordance with the requirements of the Management System standard

ISO 9001:2015

Unità Operative/Operational units (Ragione sociale-Indirizzo Sito / Registered name - Site address)	Campi di attività specifiche / Specific field(s) of activities
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE RSA E CENTRO DIURNO "MYOSOTIS" - Assistenza per varie disabilità VIA TATULLI, 1 72020 ERCHIE (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI ASSISTENZA PER ANZIANI E DISABILI NON AUTOSUFFICIENTI. DESIGN AND PROVISION OF ASSISTANCE SERVICES FOR ELDERLY AND DISABLED NON SELF-SUFFICIENT PEOPLE.
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE RSA PER ANZIANI "ROSA ALUISIO - Assistenza per anziani non autosufficienti VIA DE GASPERI, 14-16-18 72022 LATIANO (BR) ITALIA	PROGETTAZIONE ED EROGAZIONE DI SERVIZI DI ASSISTENZA PER ANZIANI E DISABILI NON AUTOSUFFICIENTI. DESIGN AND PROVISION OF ASSISTANCE SERVICES FOR ELDERLY AND DISABLED NON SELF-SUFFICIENT PEOPLE.
CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE Sede legale-amministrativa VIA ANANIA LAMARINA, 75 - 72022 Latiano (BR) 72022 LATIANO (BR) ITALIA	DIREZIONE, QUALITA', PROGETTAZIONE, APPROVVIGIONAMENTO E RISORSE

Data revisione
Revision date 30.10.2024

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IQNET

Building trust together.

Certificate

CISQ / RINA has issued an IQNET recognized certificate that the organization:

CITTA' SOLIDALE SOCIETÀ COOPERATIVA SOCIALE

VIA ANANIA LAMARINA, 75 72022 LATIANO (BR) ITALIA

has implemented and maintains a/an

Quality Management System

for the following scope:

DESIGN AND PROVISION OF THERAPEUTIC AND PSYCHOSOCIAL REHABILITATION SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS. DESIGN AND PROVISION OF ASSISTANCE SERVICES FOR ELDERLY AND DISABLED NON SELF-SUFFICIENT PEOPLE.

which fulfills the requirements of the following standard:

ISO 9001:2015

Issued on: **2024-10-30**
First Issued on: **2013-01-21**
Expires on: **2027-11-02**

All details about any legal entities, operative units and related activities included in this certificate are contained in CISQ/RINA original certificate no.: **28510/13/S**

Registration Number: **IT-89365**

Alex Stoichitoiu
President of IQNET

Mario Romersi
President of CISQ

CISQ

This attestation is directly linked to the IQNET Member's original certificate and shall not be used as a stand-alone document.

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* The list of IQNET Members is valid at the time of issue of this certificate. Updated information is available under www.iqnet-certification.com

ORGANISATIONAL MODEL UNDER D.LGS 231/2001 AND WHISTLEBLOWING

On 26.04.2022 the Board of Directors adopted the Organisation, management and control model pursuant to Legislative Decree (D.Lgs.) no. 231 of 8 June 2001 and the Code of Ethics. All those involved in the life of the cooperative, whether internal or external, have a clear reference in the adopted Code of Ethics, which prescribes the rules of conduct to be followed and sets out the ethical principles that are also relevant to the prevention of the offences referred to in D.Lgs. no. 231 of 8 June 2001.

Through the model, the cooperative Città Solidale ultimately intends to affirm and spread a business culture based on:

- Legality, transparency, ethics, fairness and respect for the rules, reaffirming that, in keeping with the rigorous principles it has adopted, no unlawful conduct can be considered permissible, even if committed in the interest or to the advantage of the company;
- Control of every stage of the decision-making and operational processes of the company's activities, in full awareness of the risks arising from the possible commission of offences.

These aims take concrete form in a coherent system of principles and of organisational, management and control procedures that make up the model drawn up and adopted by the cooperative. The model performs a fundamental preventive function with regard to the possible commission of certain types of offence that give rise to the administrative liability of the organisation. The conduct of all those involved in the life of the cooperative, in their respective roles and in carrying out their assigned tasks, must mandatorily comply with it.

At the same meeting of 26 April 2022 in which it adopted the Organisation, management and control model pursuant to D.Lgs. no. 231 of 8 June 2001, the Board of Directors also appointed Dr. Raffaele Tommasi as the Supervisory Body.

The adoption of the 231 organisational model was widely communicated to stakeholders and, subsequently, several training meetings were held with all workers to explain the contents of the model, its benefits and its practical application.

Contact: odvcittasolidale@gmail.com

Regulation for reporting offences/irregularities - whistleblowing

In December 2023 the “Regulation for reporting offences/irregularities – Whistleblowing” was drawn up. Whistleblowing is the mechanism that protects employees who, in the course of their duties within the organisation to which they belong, report unlawful conduct or situations of danger or risk capable of causing harm to third parties.

INFORMATION SYSTEM

Digital transformation is the integration of digital technology into all areas of a business, fundamentally changing how it operates and delivers value to customers. It is also a cultural change that requires organisations to continually challenge the status quo, experiment and become comfortable with change.

At Città Solidale, digital transformation involves the administrative management and all staff, as all information is held in digital locations, on the company platform hosted in the cloud. This makes us aware not only of the opportunities but also of the risks associated with the availability of information and the ability to access it from any device and any geographical location. Investments have therefore been made in technologies that raise the level of IT security.

Automation

The automation of IT processes is a priority in order to optimise the management of time spent on manual tasks. The main form of automation, implemented some time ago, is backup and recovery, followed by remote access, IT service management (such as service desks or IT asset management), identity and access management and endpoint management.

Improving security

Although automation is an important goal for infrastructure and operations, maintaining a strong security posture remains an IT priority of fundamental importance, as cyber attacks continue to evolve. In addition to focusing on improving overall security, Città Solidale is prioritising a multitude of other security-focused operations, such as vulnerability management, patch compliance and better endpoint management.

For digital transformation to take place, all staff must be trained with the aim of bringing everyone up to a minimum level of skills that ensures the full operational capability of every organisational resource. To achieve all this, the company training plan of the cooperative Città Solidale has provided for lessons by videoconference and in person, digital handouts made available on the digital platform, videos, slides, and training in the individual local units both by the coordinator and “on the job”, by qualified people from within and outside the organisation.

At the operational level, the following functions are available on the company platform:

1. Document Archive
2. Digitalised Management Control
3. Digital signature
4. Vehicle fleet management
5. Maintenance Management
6. Purchasing Management
7. Local Units Document Archive
8. Personnel Management
9. Shifts App
10. Company messaging and videoconferencing systems
11. Company E-learning platform for continuous staff training
12. Cybersecurity
13. Antivirus systems
14. Centralised, local and cloud backup of company data
15. Company platform backup
16. Company website
17. Company social media channels

The cooperative's information system, which handles the personal and confidential data of workers and of patients accommodated in the social-healthcare and rehabilitation communities, is a complex infrastructure that integrates processes, people and technologies to ensure the efficient and secure management of information. The key aspects of the measures adopted are as follows:

Management of sensitive data:

- Workers' data: Personal, contractual, pay, training and health information.
- Patients' data: Personal, clinical, diagnostic, therapeutic, social and family information.
- Formats: Both paper (documents, medical records) and electronic (databases, management software).

Fundamental principles:

- Availability: Data must be accessible to authorised staff when needed to ensure continuity of care.
- Integrity: Data must be complete, accurate and unaltered to avoid errors in clinical and management decisions.
- Accuracy: Data must be precise and up to date to reflect the actual situation of patients and workers.
- Confidentiality: Personal and health data must be protected against unauthorised access, in compliance with privacy legislation (GDPR).

Security measures:

- Data backup: Both locally and in the cloud to ensure protection against accidental loss or catastrophic events.
- Access control: Authentication and authorisation systems to restrict access to data to authorised staff only.
- Identity verification: Secure identification systems to ensure that only authorised persons can access the data.
- Protection against cyber threats: Antivirus, anti-malware and firewall systems to prevent cyber attacks.
- Software updates: Prompt installation of security patches for operating systems and application software.

Additional aspects:

- The use of specific management software, which facilitates the management of attendance, work shifts, individualised care plans (PAI and PTRI) and health documentation.
- Continuous staff training on the correct use of information systems and on privacy regulations.
- The appointment of a Data Protection Officer (DPO) to ensure GDPR compliance.

In short, the effective information system of the cooperative Città Solidale balances the need for access to data with the rigorous protection of the privacy and security of sensitive information.

DATA PROCESSING AND PRIVACY

Compliance with the legislation in force on the protection of personal data is guaranteed, as provided for by D.Lgs. 196/2003 and the amendments introduced by D.Lgs. 101 of 10 August 2018 and by European Regulation 679/2016. The Cooperative takes all necessary measures to protect the

confidentiality of the data of all guests; the Cooperative carries out a series of mandatory processing operations on such data in pursuit of its institutional purposes. Confidential data may be transmitted to other parties exclusively for the performance of their respective institutional functions, where provided for by specific legal provisions. It is also possible that they may be transmitted to other parties even where this is not provided for by legal provisions. In any case, data processing is governed by contracts appointing a Data Processor as provided for by European Regulation 679/2016. The Cooperative also guarantees data subjects compliance with Articles 15 to 22 of the European Regulation, which provide for the right of access to the personal data held, the right to rectification, the right to be forgotten (where processing is not mandatory under legal provisions), the right to restriction of processing, the right to data portability, the right to object and the right to object to automated decision-making. The Data Controller is Città Solidale Società Cooperativa Sociale. Via Lamarina, 75 – Latiano (BR). The Data Protection Officer (DPO) is Dr. Angelo Pagliara.
Contact: angelo@saam40.net