

Service Charter

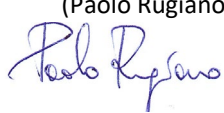
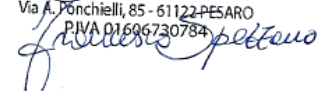
Protected Residential Facility for Non-Self-Sufficient Elderly (R3)

“MAMMA MARGHERITA”

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PRESENTATION

Dear Client,

We are pleased to provide you, through this Service Charter, with comprehensive information about our organization, the purpose of our facility, the range of services offered and how they are delivered, our quality standards, the rights of our residents, and the ways in which we safeguard those rights.

This document, in accordance with General Organizational Requirement No. 31 of the authorization manual approved by Decree No. 199 of the Head of the Authorization and Accreditation Department dated November 15, 2023, is designed to offer you the reassurance of continuous and updated knowledge regarding our policies, professional resources, human capital, structural assets, and organizational tools available to you within the facility. It is an informative tool to help you understand what kind of welcome, assistance, and care you can expect.

The Service Charter, in order to guarantee information and transparency to guests, families/guardians, and commissioning bodies, is displayed on the facility's information board and is delivered from the very first moment to those directly concerned, their families and/or guardians. It is also made available to the AST, local health services, Social Areas, General Practitioners, advocacy and citizenship associations, user associations, and various local services, and commits the managing body to guarantee the provision of services and performances at the quality levels described in this document.

With your help, through your reports and suggestions as well as your satisfaction with the services provided, and our willingness, we hope to improve the quality of life of our guests during the periods in which they use our services.

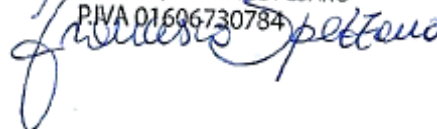
Piobbico, 2025

The Management Team

SOLIDALE COOPERATIVA SOCIALE

Via A. Ponchielli, 85 - 61122 PESARO

P.IVA 01606730784



VALUE-BASED, HISTORICAL AND CULTURAL FOUNDATIONS OF THE SERVICE

Who We Are

SOLIDALE Social Cooperative, headquartered in Pesaro (PU) at Via A. Ponchielli 85, is registered in the Regional Register of Social Cooperatives and in the National Register of Cooperatives with predominant mutuality. It has been operating as a non-profit organization in the Marche Region since 2006, managing both residential and non-residential services for the elderly and in the field of mental health. For years, it has been committed to the integrated management of social-health services and employment inclusion programs for disadvantaged individuals. In the area of residential social-health services related to vulnerability (“A”), it manages Protected Residential Facilities for the Elderly located in Piobbico, Apecchio, and Urbino, as well as the SRP2-SRP3 Psychiatric Residences “Casa Godio” in Pergola. In the area of employment inclusion for disadvantaged individuals (“B”), it manages catering services for the Protected Residences “Casa Roverella” and “Casa Aura” in the Municipality of Pesaro, as a member of the “Santa Colomba” Social Consortium. It also operates the rural tourism facility “Country House CHIGIO” in Pesaro, which includes a restaurant-pizzeria, swimming pools, riding stables, and an educational farm.

We are committed to strengthening our services through continuous investment aimed at understanding the needs of the territory, creating a welcoming environment that responds to the real needs of individuals, and supporting the motivation and professional development of our staff.

Our true ability to integrate skills and experience within partnerships, as well as our interaction with a wide range of institutional stakeholders (local authorities and social-health services) and with the territory in its various forms (individual citizens, organized civic groups and associations, informal citizen groups, professionals, etc.), ensures an organizational structure capable of managing the different levels of complexity within the service.

In particular, the Management of SOLIDALE places priority on supporting vulnerable segments of the population and is committed to guaranteeing equal rights for all citizens, with special attention to equitable access to its services.

The value-based foundations of SOLIDALE Social Cooperative are deeply rooted in its more than thirty-year history and in the culture of social solidarity that social cooperation has expressed—and continues to express—through the management of social-health services and employment inclusion programs for disadvantaged individuals, with the sole aim of pursuing the general interest of the community in promoting human development and social integration.

Corporate Mission

The Management Team recognizes as its corporate mission the promotion of mental health for individuals and the community, through the provision of appropriate and high-quality healthcare services, coordinated with the territorial services of the user’s reference AST (Territorial Health Authority), with the aim of contributing to the development of an integrated system of social safety, characterized by:

- **Clinical effectiveness of treatments**, understood as the maximum justified and permitted clinical benefit for each specifically assessed case, achieved through the adequacy and personalization of diagnostic, therapeutic, and rehabilitative interventions.
- **Efficiency of the organization’s overall action** in healthcare and support processes, understood as the rational use of resources—also from an economic and organizational standpoint—aimed at treatment effectiveness and user-patient satisfaction with the services received.

In line with the founding principles of SOLIDALE Social Cooperative, all human and professional components of the facility are committed to:

- **Caring for the assisted person**, with full respect for their dignity, needs, suffering, and hope.
- **Providing services and interventions** that excel in terms of effectiveness, appropriateness, equity, safety, timeliness, efficiency, and accessibility.
- **Promoting and ensuring** transparency in professional conduct, through the sharing of general and specific objectives, with the aim of continuously improving the organization of the services offered.
- **Encouraging** lifelong learning and the development of professional, scientific, and technical knowledge.
- **Ensuring** widespread dissemination of information, awareness of strategic and operational objectives, achieved results, and accumulated experience.
- **Fostering** collaboration and engagement, teamwork, and shared responsibility.
- **Recognizing** and valuing the commitment of all stakeholders.

Ethical Principles

The Cooperative is committed to ensuring full compliance with the Charter of Rights of Older Persons, developed in 2021 by the Commission for the Reform of Health and Social Care for the Elderly, established within the Ministry of Health. The Charter is founded on the following ethical principles:

1. *Respect for the dignity of older persons;*
2. *Principles and rights for responsible care;*
3. *Protection to support an active relational life.*

The ethical values that define the identity of the organization and guide all activities of the Residential Care Facility for the Elderly “MAMMA MARGHERITA” are:

- **Equality:** ensures equal treatment for all, without distinction of gender, race, language, social class, religion, or political opinions, while continuously upholding the centrality of the patient;
- **Impartiality:** service personnel are required to act with objectivity, fairness, and impartiality toward all users;
- **Participation:** promotes the involvement of residents and their families in rehabilitative therapy, safeguarding their right to proper service utilization. To enhance collaboration, residents and families are guaranteed the right to submit suggestions and proposals;
- **Effectiveness and Efficiency:** is committed to ensuring that services provided meet criteria of efficiency and effectiveness through the research and adoption of appropriate technical and organizational solutions. To this end, continuous attention is paid to service quality, which is regularly assessed using organizational tools adopted by the facility, whose effectiveness is subject to ongoing monitoring and evaluation by responsible personnel;
- **Continuity of Care:** guarantees users continuous and regular assistance without interruption, in accordance with the operational procedures defined by national and regional laws and regulations, minimizing any potential disruptions;
- **Communication:** is committed to ensuring courtesy, attentiveness, accuracy, and clarity in all forms of communication with residents and families, and to consistently responding to the expectations and interests of its stakeholders (residents, relatives, employees, collaborators, investors, suppliers, institutions, local authorities...);
- **Confidentiality:** ensures the confidentiality of the information in its possession and refrains from seeking or processing sensitive data, except in cases of explicit and informed authorization and/or compliance with applicable legal regulations;
- **Safety:** is committed to enhancing the effective and efficient management of technological resources necessary to promote and consolidate a culture of safety, fostering risk awareness and requiring responsible behavior from all staff;
- **Environmental Protection:** acknowledges the importance of respecting the environment in order to minimize any negative impact.

PURPOSE AND OBJECTIVES OF THE SERVICE

Purpose

The aim of the Residential Care Facility for Non-Self-Sufficient Elderly Persons (R3) is to enhance each individual's capabilities by supporting personal recovery through accompaniment, starting from their specific needs and those of their primary relational system (e.g., family). The facility ensures that residents can make use of their physical, emotional, social, and intellectual abilities to achieve the highest possible level of autonomy compatible with their condition, enabling full participation as citizens in community life. This is achieved through long-term care, functional recovery and maintenance treatments, including respite interventions for caregivers of non-self-sufficient individuals.

Objectives

The care objectives are aimed at safeguarding clinical and psycho-functional stability and preventing and/or slowing the deterioration of the elderly person's residual functions. Specific objectives include:

- a) **Preserving the elderly person's state of balance**, preventing any form of maladjustment or social exclusion, deterioration of health, and psycho-functional decline;
- b) **Providing personalized services and care** through the development of individualized care plans, respecting cultural, political, and religious backgrounds, and honoring the rhythms and habits of the elderly, allowing residents to maintain a strong sense of identity as active members of the community they inhabit;
- c) **Ensuring the highest standards** of care and assistance in terms of appropriateness, timeliness, effectiveness, consistency, and continuity, as required by the user's condition;
- d) **Improving quality of life** and social integration for elderly individuals, safeguarding their rights as citizens, and preventing any form of marginalization, health deterioration, or psycho-functional decline;
- e) **Promoting full socio-relational integration**, avoiding isolation, and offering a relational life—both within and outside the facility—that allows residents to express the richness of their personality;
- f) **Developing continuous improvement actions for services** and organizational processes, focused on user attention and satisfaction;
- g) **Delivering essential services and appropriate care** by integrating interventions with a rational use of all available resources.

Management Model And Methodology

To ensure the quality of the services provided, a participatory management model is adopted. This model welcomes the “voice” of the elderly, listens to families, considers the personal characteristics of residents, and uses tools designed to ensure openness to the community and accountability toward the elderly and their families. It also facilitates collaboration with volunteer associations and informal networks, and promotes initiatives within the local area.

Cultural Model: Living The Residence

The management model is based on a concept of elderly residence where each person perceives themselves as a resident of the home, not merely a guest receiving care. The management approach engages with the elderly in their experience of living in the Residence, with a vision of accompaniment that respects their need for involvement and sharing. This commitment embodies the affection and humanity of care, making the difference between “living” and “being hospitalized.” The concept of living requires continuous adaptation; the emotional conditions experienced by elderly residents may make the place feel dark and oppressive—or, conversely, bright and full of hope. Caring for a person represents a cultural choice for the Residence, even before being a technical one. It transcends the meaning of therapy, surveillance, or containment, becoming a humanizing dimension of “care as accompaniment.”

Every care intervention is aimed at interrupting the chronic process that has distanced the individual from their well-being, through personalized environments, attention to physical appearance, avoidance of isolation, and the promotion of a relational life—both internal and external—by integrating the Residence into the local community. This ensures full socio-relational integration and continuity of relationships, allowing residents to express the richness of their personality.

Methodology: Gentle Care

In service management, the Residence adopts the Gentle Care methodology, characterized by a prosthetic approach to care that supports rather than challenges the user. Its primary goal is well-being, understood as the best possible functional level for each individual.

Priority is given to care interventions that reduce stress and to programs aimed at supporting existing functions.

RESIDENTIAL TYPE

The Facility

The Residential Care Facility is located in Piobbico (PU), at Via G. Di Vittorio snc, and is leased to the SOLIDALE social cooperative. The building has been renovated and is equipped with a technological system fully compliant with all safety regulations and applicable national and regional laws.

The facility consists of:

- A semi-basement level housing the laundry and mortuary room
- A ground floor with general services including kitchen, gym, infirmary, living and dining areas
- 12 double rooms accommodating 24 residents
- 1 single room, for a total of 25 beds

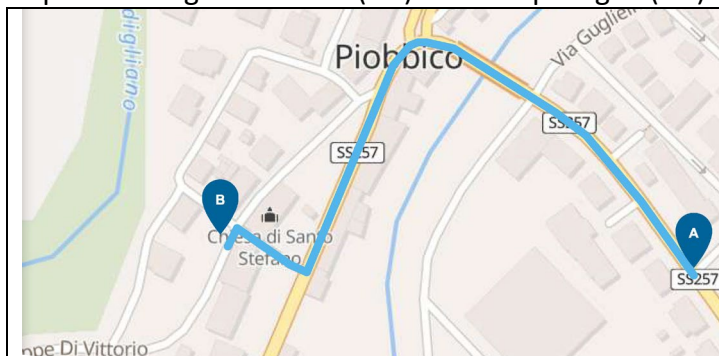
The facility is situated in the town center and is well connected to local services and communal spaces within Piobbico.

How to Reach the Facility

MAP



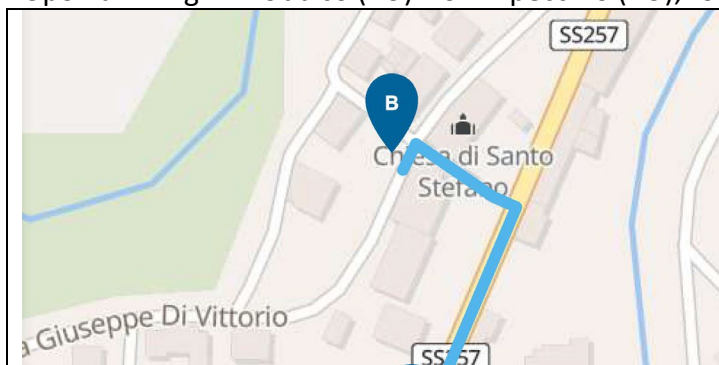
Upon arriving in Piobbico (PU) from Acqualagna (PU) follow these directions:



from Via Santa Maria in Val d'Abisso (SS 257):

- Turn left onto Via Dante Alighieri
- Turn right onto Via Roma
- Continue straight onto Via G. Di Vittorio

Upon arriving in Piobbico (PU) from Apecchio (PU), follow these directions:



from Via Dante Alighieri (SS 257):

- Turn left onto Via Roma
- Turn left onto Via G. Di Vittorio

Target Audience

The Protected Residence is a territorial residential facility (R3) with a high level of social-healthcare integration. It is designed to accommodate, either temporarily or permanently, elderly individuals who are non-self-sufficient due to stabilized physical, psychological, sensory, or mixed conditions that cannot be managed at home and do not require complex medical care.

The facility also offers short-term admissions to provide relief for families and is open to the local community, serving as a resource for support, home care promotion, and fostering social relationships.

ACCESS TO SERVICES

Admission

Admission is managed through the Integrated Assessment Unit (UVI) of the guest's local Health District. Both residents of the Municipality of Piobbico and non-residents may be admitted.

The admission request must be submitted using the specific forms provided by the managing entity and signed by the elderly applicant or their family member/legal guardian/support administrator.

Entry is coordinated with the Facility Manager following confirmation of availability (entry requirements + available bed), upon presentation of the guest's healthcare, social-healthcare, and social documentation, and the signing of the following documents:

- Consent to the services provided by the facility;
- Acceptance of the community life regulations;
- User Admission Contract, including commitment to pay the monthly fee by the guest or their legal financial supporters;
- Delivery of the guest's healthcare and social documentation;
- Inventory of the guest's clothing and personal belongings.

Waiting Lists

Approved admission requests will be placed on waiting lists based on chronological order and prioritized as follows:

- a) LIST FOR RESIDENTS OF PIOBBICO
- b) LIST FOR NON-RESIDENTS

Care Process

Pre-admission. Before admission, the guest's family/support administrator meets with the Facility Manager to discuss the individual's needs, lifestyle habits, and the care methods previously used by the family, ensuring continuity of care. During this meeting, the guest's admission is planned in detail. The designated family member/support administrator finalizes admission procedures with the Facility Manager or their delegate.

Admission. On the day of admission, the guest is welcomed by the facility's reception team and accompanied to their room, where personal items, clothing, and linens are stored appropriately. The new guest is introduced to their roommate and other residents, and gradually shown the facility's common areas and their assigned seat in the dining room.

Family members are also welcomed with care and informed about the facility's organization.

Staff members provide attentive support from the first moment, helping the guest integrate naturally and become familiar with other residents and the facility's spaces.

Registration of Guest Property. The Facility Manager records the guest's clothing, personal items, and documentation on dedicated forms, which are stored in the guest's personal file.

Nurse Interview and Assessment. The nurse conducts an interview with the family/support administrator to gather detailed health information and therapeutic prescriptions, followed by a clinical assessment of the guest's condition upon entry. These details are documented in the Nursing and Care File, which tracks the guest's journey throughout their stay.

On the day of admission, a meeting is also held with the designated Case Manager/Tutor to collect information about the guest's habits.

Observation Period

Admission includes an observation period of approximately one month, after which the guest's placement may be confirmed or reconsidered.

During this phase, a Case Manager/Tutor is assigned to support the guest and their family/support administrator for proper integration.

This period also serves to assess the guest's suitability for community life and gather information for the development of the Individual Care Plan (PAI). Observations are documented using PAI planning forms, and appropriate tests and evaluation tools are administered.

At the end of the trial period, the care team develops the PAI, which is signed and accepted by the guest/support administrator.

The PAI is periodically updated to reflect changes in the guest's condition and progress toward care goals.

Discharge

Guests may request discharge at any time with 30 days' notice, by submitting a written declaration either personally or through their legal guardian.

Discharge may also be initiated by the facility in the following cases:

- a) Changes in the guest's psycho-physical condition, certified by the General Practitioner and assessed by the UVI and/or CDCD, requiring transfer to a different type of care facility;
- b) Severe and verified refusal of community life by the guest, resulting in significant physical decline or behaviors incompatible with continued residence.

Discharge may also be initiated by the facility in cases of unpaid fees or serious environmental incompatibility.

Upon discharge, if the guest returns home, the facility provides the family with all necessary care instructions. If transferred to another facility, a copy of the guest's social and nursing care file is provided.

In the event of death, the facility immediately informs the family and subsequently the competent authorities, attaching the documentation required by current health regulations.

In cases of discharge or death, personal belongings, clothing, and linens are returned to the guest or their heirs. If refused, these items become property of the Protected Residence, which will use them as deemed appropriate.

Hospitality Agreement

The standard model of the hospitality agreement used is provided in **Annex 1)** of this document. Signing the User Admission Agreement implies automatic acceptance of all services, including any enhancements.

The daily fee is established annually by the Administration of the managing entity and varies according to the following service categories:

- Non-self-sufficient user in a single or double room under private arrangement (R3);
- Non-self-sufficient user under agreement with the AST in a single or double room, with a co-payment borne by the user (R3).

The specific fee amounts are listed in **Annex 2)** of this document. Admission for users under agreement is subject to prior authorization from the relevant AST and the signing of a contract by family members or another designated person who guarantees payment of the user's share of the admission fee.

The fee includes all aspects of direct personal care, healthcare and assistance services, as well as hospitality-related services concerning the stay. The following services are excluded from the fee: personal hygiene items, minor daily expenses, pharmaceutical co-payments, specialist visits, costs for accompanying the patient to other facilities for exams or consultations, fees for private consultations, and services such as hairdresser, beautician, etc.

Monthly fees must be paid by the user via bank transfer or direct debit (RID) within 10 days of invoice issuance at the end of each month. Any reimbursements or compensations to the user will be made exclusively via bank transfer to the user's account.

Retention of Accommodation in Case of Absence

In the event of temporary absence, the Residence reserves the right to charge the daily fee under the following conditions:

- 1) In case of hospitalization or absence, the room remains reserved for the Guest, who is required to pay the full daily fee for absences of less than 15 days within the reference month. For absences exceeding 15 days within the same month, the monthly fee will be reduced by 50%.

- 2) For guests under agreement with the AST, in case of hospitalization or absence, the accommodation will be retained until discharge. For days of absence from the facility, the daily fee will be reduced by 50%.

ORGANIZATION OF CARE AND ASSISTANCE SERVICES

Services are organized in accordance with current regulations through the adoption of specific care and assistance protocols.

Care Pathway

The care pathway is a problem-solving and educational process aimed at helping the individual achieve the highest possible quality of life—physically, functionally, socially, and emotionally—with minimal restriction of personal choices.

Planning of the care pathway follows an “open system” approach, ensuring adaptability and flexibility to manage the diverse and evolving needs of the guests. Service organization is designed to replicate family-like rhythms, respecting guests’ habits as much as possible while balancing community life requirements. It encourages participation of guests and their families in facility activities and promotes relationships and integration with the local community.

Guest care is structured around “personalized projects” based on:

- A concept of the user as a rights-bearing individual, whose autonomy and freedom of choice must be fully respected from the moment of admission. This ensures that even the highest-quality services are not solely determined by staff decisions. In this way, privacy, personal rhythms, and identity transcend a purely assistential model and become part of a “care as accompaniment” philosophy.
- The principle that all care interventions should be perceived by the user as opportunities that respect their needs and personal living space.

This personalized approach marks a shift from task-based care to project-based care. It integrates clear operational responsibilities and performance outcomes with a stronger focus on results and accountability.

All care activities will prioritize humanization and personalization, ensuring:

1. Development of Individualized Care Plans (PAI);
2. Operational flexibility to meet user needs;
3. Stability of the care team, both support and nursing staff;
4. Creation of networks of empathy and civic participation around guests, through collaboration with institutions and community stakeholders.

Individualized Care Plan

The concept of “personalization” in service quality is not merely organizational it is the essence of care itself. Humanization and personalization require a reconfiguration of organizational models, restoring human and solidarity values.

Personalization means adapting professional actions to the subjective characteristics and needs expressed by the individual.

It is not the user who must adapt to the care system, but the professionals who must tailor their interventions to the guest’s needs. Care staff are expected to adjust their professional approach and organizational variables to the unique human being in their care, recognizing the otherness inherent in the relationship.

Service planning follows a project-based methodology grounded in interdisciplinary teamwork, structured in the following steps:

- Identify care objectives
- Break down general objectives into sub-objectives
- Define actions needed to achieve objectives
- Verify execution of planned actions
- Evaluate the relationship between expected objectives and actual outcomes
- Implement corrective actions by modifying objectives or methods

Operational intensity and continuity of care are essential to:

- Restore the best possible functional level and quality of life
- Consolidate and maintain the optimal bio-psycho-social balance of the elderly
- Screen for emerging needs
- Prevent deterioration of residual functions

The Facility Manager ensures continuity of team activities across three phases of user management:

- Operational assessment of the Individual Work Plan (PAI)
- Management planning (work plans)
- Interprofessional management of the user in coordination with territorial service networks

Organization of Work Plans According to Individualized Care Plan

Each elderly guest will have a personalized care project respecting their personal identity, which conceptually represents:

- The **right to personalized** treatment (maximum adaptability);
- The duty of care providers to avoid standardized services and adopt differentiated, **personalized projects** (maximum flexibility);
- A clear starting point (assessment and needs) and destination (objectives and evaluation);
- **Teamwork** instead of fragmented, isolated interventions.

All care interventions will be planned through **work plans** aligned with the guest's daily activities and the implementation of the individualized care plan. Work plans, operational protocols, work instructions, and management procedures adopted by the Residence ensure that all staff activities are organized around personalized projects.

Care Procedures and Protocols

Implementation of work plans and services is governed by **care procedures and protocols** adopted by the Residence. These protocols provide a rigorous codification of operational tasks to ensure correct execution of care techniques. They are regularly updated based on improvements from innovative methods and tools.

Presentation and notification of work plans and care protocols will be conducted by the Facility Manager through dedicated training sessions with staff.

Operational Methods for Integration and Coordination Among Professionals

In the adopted organizational methodology for professional integration, all involved professionals are considered functional actors within the service management system.

During team meetings, staff members are encouraged to share ideas, experiences, and information as a means of fostering the necessary synergies to achieve the overall goal of improving the user's quality of life. Ongoing communication among professionals takes place at each shift change via the handover register, a structured space for reporting specific events or situations concerning the user.

Information exchange between professionals is essential to align all activities with the shared objectives.

Typical Daily Schedule

TIME	ACTIVITY
06:30/09:00	Guest is assisted in waking, personal care, and hygiene.
08:00/09:30	Breakfast; guests with difficulties or bedridden are assisted with feeding and medication.
09:00/11:30	Assisted bathing, mobilization, and social activities.
11:30/12:00	Preparation for lunch.
12:00/13:00	Lunch; assistance with feeding and therapy as needed.
13:00/17:30	Afternoon activities; rest permitted upon medical indication or personal request. Snack provided.
17:30/18:00	Preparation for dinner.
18:00/19:30	Dinner; assistance with feeding and therapy as needed.
19:30/21:00	Guest is accompanied to their room, assisted with hygiene and preparation for sleep, and given evening medication.
21:00/06:30	Night rest; monitoring and care as needed, repositioning and mobilization per care plan.

The organization of daily routines and activities respects the individual needs and life rhythms of each guest, in alignment with their personalized care plans (PAI). Work plans for different professional roles (Nurses and Healthcare Assistants) provide detailed guidance on the services to be delivered under the PAI.

SERVICE FEATURES

The facility commits to providing the following services under the financial terms outlined in the hospitality agreement:

A. HEALTHCARE AND ASSISTANCE SERVICES

Medical Care Service

Basic medical care is provided by the guest's General Practitioner (GP) under the National Health Service (S.S.N.). Upon admission, the guest retains their relationship with their GP. The Protected Residence supports this continuity by offering logistical assistance and ongoing collaboration through its nursing staff, with scheduled or on-demand consultations, in accordance with national and regional agreements.

The GP maintains clinical responsibility for their patient and ensures continuity of care. GP visits are documented in the GP Access Register and recorded in the medical documentation (GP SIGNATURE REGISTER – GUEST LIST BY DOCTOR – MEDICAL VISIT SCHEDULE PER USER).

Nursing Care Service

Nursing care is provided by two nurses, organized according to each guest's PAI, with an average of 20 minutes of care per user per day, totaling approximately 8.33 hours daily, distributed as follows:

- 1 nurse in the morning (07:30–13:50 = 6.20 hours), daily
- 1 nurse in the afternoon (17:30–19:30 = 2.00 hours), daily

Nursing services are delivered in accordance with the care load defined in the PAI and the duties outlined in the organizational chart for the "Nurse" role.

The GP determines therapies and provides medical instructions to facility staff.

Special attention is given by nursing staff to the prevention of pressure ulcers, urinary tract infections in catheterized patients, and falls among elderly guests.

Medical supplies and scheduled pharmaceutical assistance are the responsibility of the guest.

Personal Social-Healthcare Assistance

Direct personal care is provided by an average of 8–9 Healthcare Assistants (OSS), organized according to each guest's PAI, with an average of 88.80 minutes of care per user per day (R3 level), totaling 37 hours daily, distributed as follows:

- 2 OSS in the morning (07:00–14:00 = 14 hours), daily
- 2 OSS in the afternoon (14:00–21:00 / 14:00–20:00 = 13 hours), daily
- 1 OSS during the night shift (22:00–07:00 = 10 hours), daily

Social-healthcare services are delivered in accordance with the care load defined in the PAI and the duties outlined in the organizational chart for the “Healthcare Assistant (OSS)” role.

OSS staff provide personal assistance (hygiene, daily living support, etc.), while encouraging guests to use their own abilities. Care staff aim to make the guest's stay as comfortable as possible, minimizing adjustment-related discomfort. They are responsible for welcoming, assisting, and caring for the guest in accordance with medical, nursing, and physiotherapy directives. Specific care tasks are defined by the coordinators in the work plans.

Animation Service

The animation activities are designed according to the guests' needs, aiming to make the most of each individual's preferences while respecting their personalities and avoiding excessive pressure to participate.

Subject to each guest's health condition, the facility organizes celebrations, outings, social gatherings, and activities, often with the support of volunteer associations and informal networks that collaborate with on-site staff.

B. HOSPITALITY SERVICES

Accommodation

The facility is organized into units equipped with all services required by current regulations and offers guests single or double rooms with private bathrooms.

Meals and Catering

The catering service is managed internally by specialized staff directly employed by the company. The menu follows a four-week rotation and is structured according to dietary guidelines approved by the competent Local Health Authority (A.S.L.). Guests may choose in advance between two daily menu options.

Meal times are approximately as follows:

- Breakfast: 08:45 – 09:15
- Lunch: 12:00 – 13:00
- Afternoon Snack: 15:00 – 15:30
- Dinner: 18:00 – 19:30

Personalized menus are available upon appropriate medical evaluation.

Hygiene, Sanitization, Disinfection

Resident rooms, bathrooms, and common areas are cleaned and sanitized daily. Disinfection of rooms and furnishings is carried out at regular intervals and whenever required by environmental microbiological checks.

Laundry, Ironing, and Wardrobe

Laundry and ironing services are included in the accommodation fee for all guests. Garments are labeled and returned to rooms by staff.

Personal Belongings

The facility's management assumes no responsibility for valuables kept personally by guests in their rooms. The facility acts as a gratuitous custodian in accordance with Articles 1766 et seq. of the Italian Civil Code and is only responsible for items formally entrusted to its care. The Facility Manager issues a deposit receipt, which must be presented for item retrieval.

Upon delivery of personal belongings, an inventory report is prepared and signed by both the guest and the Facility Manager. Likewise, upon discharge or death, a final inventory report is issued for the return of personal items.

It is the guest's responsibility to exercise due diligence in safeguarding their belongings and to take appropriate precautions regarding their use and management.

Reception / Switchboard Service

Reception services are provided by care staff, including welcoming visitors. Each guest may request the Facility Management to contact family or friends.

Extra Services

The following services are available upon request and are charged to the guest: hairdresser, barber, podiatrist, and pedicure, provided by external professionals. Physiotherapy rehabilitation services are also considered extra and charged separately.

C. SOCIAL AND ADMINISTRATIVE SERVICES

Social Assistance

The Facility Management provides all necessary support for social-healthcare procedures, admissions, and discharges, in coordination with district operational units and local social workers.

Administrative Services

Administrative services are provided by Solidale's staff, coordinated by the Facility Manager, covering all management-related aspects.

Religious Services

Each guest is guaranteed the opportunity to request religious services according to their faith.

Extra Services Not Included in The Admission Contract

The following services are not included in the accommodation fee and are charged to the guest:

- Hospital care for admissions or stays in healthcare facilities
- Paid specialist treatments
- Medications and medical aids
- Personal expenses (e.g., cigarettes, luxury items, clothing)
- Staff accompaniment for medical or personal visits outside the guest's municipality of residence

INFORMATION – COMMUNITY LIFE – FAMILY VISITS AND PARTICIPATION

The rules governing community life are detailed in the Facility Operating Regulations, which are provided to and accepted by the guest upon admission. These regulations outline the standards of conduct necessary to ensure respectful coexistence and the protection of each guest's rights.

Guests and their families are informed of their rights and responsibilities to promote active involvement in the care process, both at the time of admission and throughout the stay, through documented meetings with the guest and their relatives.

Each guest has the right to be informed in a simple and clear manner about the treatments provided and the foreseeable consequences of their choices, and to access their personal documentation in accordance with the procedures adopted by the facility.

Visits from Relatives And Friends

The Protected Residence is open daily to family members and visitors from 10:00 to 12:00 and from 16:00 to 18:00. Exceptions to these visiting hours may be authorized by the Facility Manager.

Requests for visits outside standard hours must be arranged with the Facility Manager based on individual circumstances.

Exceptions may be granted when there are objective impediments to observing standard hours or specific care needs of the elderly guest.

Visitors are expected to respect the privacy of other guests and avoid interfering with staff duties.

Family Participation

The facility encourages the participation of guests and their families in community life. Where family members are able to contribute, collaboration is requested based on the specific needs of each guest and the availability of the family, with the aim of maintaining emotional, relational, and supportive ties with their original family unit.

During periodic family meetings with the Management, all issues and suggestions related to facility life are discussed. A feedback and suggestion form is available at the Management office for anyone wishing to use it.

Family members are encouraged to collaborate with the Protected Residence staff in the following areas:

- Maintaining meaningful relationships with their hospitalized relative
- Washing garments that cannot be laundered by the facility
- Managing seasonal clothing changes for items not stored at the facility
- Renewing clothing, footwear, and personal linens
- Organizing occasional visits to the family or relatives

The Facility Manager will:

- Maintain ongoing communication with families to ensure continuity in relationships and updates, and to encourage participation in service planning and evaluation
- Ensure that families are consistently informed and actively involved in the design and review of the Individualized Care Plan

- Oversee and manage relationships with families from the initial admission phase, organizing structured meetings to understand their needs and coordinate interactions based on their availability and preferences

In the event of hospitalization, the responsibility for the guest lies with the family/support administrator (ADS) until the guest returns to the facility.

Upon discharge, if the guest returns home, the facility will provide the family with all necessary information regarding appropriate home care. If transferred to another facility, a copy of the Nursing and Care File will be provided.

Family members/support administrators may access the guest's personal documentation either by requesting a copy or by submitting an information request using the appropriate forms provided by the Facility Management.

Service Quality Representation Group

To ensure the protection of guests and improve service quality, the Protected Residence may establish a "Service Quality Representation Group" composed of:

- Two guests elected by all residents
- Two representatives elected by the guests' families
- The Facility Manager
- Two staff representatives (1 Nurse and 1 Healthcare Assistant – OSS)

If activated, the Representation Group meets at the facility at least twice a year (March and September), following formal invitations and notice posted on the bulletin board. Its responsibilities include monitoring facility operations, verifying achievement of objectives, and proposing improvements to service quality and delivery methods. Proposals will be evaluated by the Facility Manager for potential implementation.

Each meeting of the group will be documented in minutes signed by all attendees.

Complaint Submission and Management Procedures

The Facility Management is committed to receiving feedback or complaints and providing prompt and effective responses to individual guest/user dissatisfaction. It will outline the initiatives to be undertaken to address the reported issues, with the aim of generating a comprehensive process of service quality improvement.

The guest, or their representative, may submit complaints or suggestions using the dedicated reporting form provided in Annex 3 of this document.

All reports and complaints are handled promptly and in any case within 15 days of receipt.

Every six months, the Facility Management will prepare a Complaint Report to improve the organization of services based on the feedback received.

Privacy Protection

Patients' health data are protected under current regulations on Professional Confidentiality (Articles 622 and 326 of the Italian Code of Criminal Procedure).

Personal data are protected in accordance with current privacy legislation. Staff working in the facility are bound, within their professional competencies, by both official and professional confidentiality obligations.

ORGANIZATIONAL STRUCTURE – HUMAN RESOURCES

The organizational structure of the human resources employed in service delivery is outlined in the following annexes to the Service Charter:

- Annex 4: ORGANIZATIONAL CHART
- Annex 5: FUNCTIONAL CHART

Staff are coordinated by the on-duty Nurse, who is responsible for all care activities provided to users.

The Facility Manager is present at the residence from Monday to Saturday with flexible hours (morning or afternoon) and is available on-call 24 hours a day.

The types and number of personnel employed ensure the following levels of care:

PROFESSIONAL ROLES – R3 CARE LEVELS (25 beds) with 24-hour presence of social-healthcare personnel				
Activity/Function	Qualification	Min./Day/User	Daily Hours	Weekly Hours
Facility Manager	Coordinating Nurse	--	--	6.00
Nursing Care	Nurse	20	8.33	59.00
Social-Healthcare Assistance	Healthcare Assistant (OSS)	88.80	37.00	259.00

Staff Recruitment

Staff selection is a key step in ensuring the quality of services provided. Best practices adopted by SOLIDALE include a rigorous selection process conducted by the Human Resources Office.

Onboarding and Training Plan for New Staff

Each new employee undergoes a 30-day probation period and is supported during onboarding by an experienced colleague. Training consists of a “on-the-job” phase lasting three work shifts.

Upon hiring, the new employee receives all necessary information for proper professional conduct, including work methodology, task execution, and personal safety guidelines.

The Facility Manager evaluates the new employee using a dedicated assessment form, which is submitted to the Company Management by the 25th day of actual work to confirm or reject the probation outcome.

Staff hiring is carried out in compliance with the DECLARATION OF GUARANTEE regarding adherence to national collective labor agreements (CCNL) signed by the most representative trade unions at national and regional levels.

Procedure for Use of Equipment and Personal Protective Devices

As part of the training and information process, each employee receives a Kit containing:

- Job description and task execution guidelines
- Procedures and care protocols
- Safety materials (including explanatory content on Legislative Decree No. 81/08 on workplace safety)
- Necessary tools and protective equipment (e.g., aprons, gloves, etc.)

Staff Training and Professional Development

The planning of professional development for staff begins with an analysis of training needs through the assessment of professional competencies. This process identifies existing skills and specific training requirements, allowing the design of appropriate training pathways for both continuing education and professional requalification.

Staff training is managed by the Training Coordinator, who prepares the annual training and development plan in collaboration with experienced professionals and accredited training organizations.

Objectives

- *Deepen knowledge and skills related to the complex reality of life and care for non-self-sufficient elderly individuals, focusing on the critical aspects of the helping relationship and the tools for its implementation.*
- *Acquire competencies to prevent and address situations of need and discomfort, promote family and social integration, avoid user isolation, and support individuals in managing the challenges of their condition.*

The staff training program includes:

- *Permanent basic training for all staff, totaling 10 hours per year, structured into modules defined by the annual training and development plan. This enables the integration of theoretical knowledge and technical skills with best practices, establishing a shared operational foundation.*
- *Specific training sessions that systematize experience to enhance performance, reduce burnout risk, and lower staff turnover.*

The annual training and development plan includes a monitoring system that ensures compliance with Continuing Medical Education (ECM) requirements.

The facility maintains documentation verifying staff participation in accredited Basic Life Support Defibrillation (BLSD) courses, with scheduled retraining in accordance with sector technical standards. At least one BLSD-certified staff member is present per shift.

Identification of Professional Roles

In compliance with regulations and with the aim of improving service quality, all staff members wear identification badges displaying their photo, name, and professional title. This ensures that guests and stakeholders can easily recognize the various professional roles within the facility.

SERVICE QUALITY STANDARDS

Quality standards are defined based on the minimum structural and organizational requirements established by current regulations for facility authorization and accreditation.

Dimensions of Quality

The annual Quality Plan, overseen by the Corporate Quality System Manager, defines objectives related to overall service delivery and sets reference standards to ensure continuous improvement in the following areas:

1. *Organizational Quality*
2. *Care Quality*
3. *Professional Quality*
4. *Perceived Quality*

Quality Monitoring and Evaluation

Efficiency and effectiveness, as essential components of quality, are monitored through dedicated evaluation forms and rating scales. Service adequacy is assessed both in relation to the needs that generated the interventions and the broader goals guiding the care planning process.

Progress in therapeutic-rehabilitative treatment is monitored through biannual updates of the Personalized Therapeutic Rehabilitation Plan (PTRP).

Evaluation, based on monitoring data, occurs in the following phases:

a) Ongoing Evaluation:

- Assessment of organizational processes for delivered services
- Evaluation of outcomes from the Individualized Care Plan
- Measurement of perceived quality by service users

b) Post-Implementation Evaluation:

- Performance assessment of delivered services
- Evaluation of effectiveness and efficiency indicators

c) Impact Evaluation:

- Assessment of innovative effects in personal care services
- Evaluation of changes in perceptions of the services provided

Quality Measurement Indicators

Quality is analyzed within each service through the achievement of baseline targets defined by the set of monitoring and evaluation indicators outlined in Annex 6 of this document.

Every six months, the Facility Manager prepares reports based on indicator data, which are shared with Corporate Management. Any recommendations are incorporated into the Quality Improvement Plan, a shared tool for the ongoing enhancement of service standards for users.

User Satisfaction and Service Appreciation

By analyzing guest satisfaction data, Corporate Management implements corrective actions aimed at improving service quality and fostering trust, understanding, and credibility.

To assess perceived quality, a service satisfaction questionnaire is administered annually to all users and/or family members. A separate catering satisfaction questionnaire is also administered annually to all users and/or family members.

The Facility Manager prepares a Satisfaction Questionnaire Report to improve service organization and quality based on user-perceived quality.

METHODS OF CONNECTION AND COORDINATION WITH THE LOCAL SERVICE NETWORK

To improve the quality of services, the Facility is committed to building around its guests a network of empathy and civic participation through ethical practice and collaboration with institutions and other local stakeholders working to support the residents. The goal is to foster territorial integration and contribute to optimizing the response entrusted to the local service network.

As part of its networking efforts, the Facility ensures:

- Information on elderly rights and available local resources
- Support throughout the care pathway (including contact with specialist services)
- Communication with family members
- Coordination with the guest's General Practitioner

The Facility also maintains ongoing relationships with:

- Municipal and District Social Services
- Local Health Services
- General Practitioners
- Local associations and religious organizations
- Volunteer associations

Operational methods of connection and coordination reflect the networking approach adopted by the Protected Residence, aimed at actively engaging the social context and recognizing the valuable energies needed to combat marginalization and social hardship, while addressing the challenges of aging with dignity.

Local Service Network

The Facility operates in close integration with all other territorial services, promoting a unified care system through the local service network. Within the framework of the Individualized Care Plan (PAI), this network ensures various levels of assistance based on individual needs, activating interventions that develop within and alongside the local community, in coordination with all available social resources.

The Facility Manager:

- Plans and organizes services in coordination with territorial services
- Maintains relationships with the Integrated Assessment Unit (UVI) and Health Districts for users under agreement with the AST
- Establishes preliminary contact with the hospital and emergency room in Urbino for potential guest admissions

The Protected Residence “MAMMA MARGHERITA” aims to be a well-rooted and integrated residential hub within the local territory. Consequently, its guests are considered full-fledged residents. The Facility seeks to develop relationships with all local entities so that it becomes a point of reference and social aggregation. The objective is to fully realize the concept of an “open service” that promotes a new culture of reciprocity and encourages interaction and collaboration with external resources, the territorial service network, and volunteer organizations.

Territorial Synergy Strategy. The pursuit of synergy with the local territory is a working philosophy aimed at promoting the well-being of guests through the following strategies:

- Encouraging interaction between the Facility and its surrounding environment, understood as a relational habitat, and enhancing the role of an “educating community” as a vehicle for inclusion
- Establishing social inclusion groups capable of influencing public opinion (e.g., families, volunteer associations, cultural organizations)
- Developing tools to share the life of the Residence with the outside world
- Participating in territorial Program Agreements

Volunteering

The Facility’s Corporate Management recognizes the value of volunteer activities as expressions of solidarity and engagement with social and healthcare issues. It is therefore committed to supporting volunteer efforts as complementary—not substitutive—of employed staff.

The use of volunteer workers is acknowledged and encouraged through formal agreements with local volunteer associations. The presence of volunteer staff, in a complementary and non-substitutive role, will not exceed 30% of the number of paid staff.

Interns and trainees are accepted under agreements with external sending institutions and are assigned an internal tutor for supervision.

Volunteer and trainee staff will always work alongside employed personnel. Volunteers are not permitted to carry out activities during nighttime hours (20:00–06:00).

ACTIVE INSURANCE POLICIES

The Facility holds appropriate insurance coverage for risks related to accidents or damages suffered or caused by guests, staff, or volunteers.

GENERAL INFORMATION

⇒ Smoking

Smoking is strictly prohibited in all common areas and corridors of the Facility. It is only permitted in the garden and on the terraces.

⇒ Tips and Gifts

Staff members are not allowed to accept gifts in kind or money, nor to receive any benefit for services related to their professional duties.

CONTACTS

⇒ FACILITY

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ANNEXES

- Annex 1: Standard Hospitality Agreement Template
- Annex 2: Admission Fee Schedule
- Annex 3: Complaint and Suggestion Form
- Annex 4: Organizational Chart
- Annex 5: Functional Chart
- Annex 6: Quality Measurement Indicators

REGULATORY REFERENCES

- Legislative Decree No. 502 of December 30, 1992
- D.P.C.M of May 19, 1995
- Law No. 273/1995
- Law No. 27/2012
- Legislative Decree No. 33/2013
- D.P.C.M of November 29, 2001
- Regional Law No. 21/2016
- Regional Regulation No. 1/2018
- DGR No. 1412/2023
- Decree No. 199 of November 15, 2023 issued by the Head of the Authorization and Accreditation Department