Service Charter

Residential Rehabilitation Centre

VILLASAN PIETRO

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1.Introduction

a. Villa San Pietro

Villa San Pietro is a residential health and social care facility managed by the Codess Sociale cooperative. It comprises two independent Rehabilitation Units: the **Rehabilitation Centre and the "Il Soffio" Therapeutic Community.**

The Rehabilitation Centre consists of two Residential Units, named "Ora" and "Pelér", each of which can accommodate up to 18 patients, both from Trentino and from outside the Province, upon referral by the relevant Community Mental Health Service. The Rehabilitation Centre specialises in the psychiatric rehabilitation of adult patients with psychotic spectrum disorders and provides programmes with different levels of rehabilitation intensity (high, medium and low). Each programme is managed by a dedicated rehabilitation team and tailored to the specific needs of each individual patient.

The "Il Soffio" Therapeutic Community consists of a single Operational Unit and can accommodate up to 10 patients aged between 13 and 22 who reside within the Province. For patients under the age of 18, admission follows a referral from the local Child and Adolescent Neuropsychiatry Service. For adult patients, referral is coordinated by the Community Mental Health Service.

Continuing the tradition of Villa San Pietro, both Rehabilitation Units may also admit patients subject to judicial measures, for whom dedicated rehabilitation programmes are available.

b. The History of Villa San Pietro

Villa San Pietro has been providing care and support to people experiencing mental health difficulties since 1993, initially through the work of the Silenziosi Operai della Croce Association. In 2003, management of the facility was transferred to Villa San Pietro S.R.L., which was subsequently succeeded by Codess Sociale in 2010.

In the summer of 2016, Villa San Pietro moved to its current, newly built facility. This structural change was soon followed by an extensive process of service redesign, which culminated in January 2017 with the official opening of the new premises.
In July 2017, Villa San Pietro obtained institutional accreditation from the Autonomous Province of Trento for 20 residential psychiatric care places. In May 2019, the accreditation was extended to a total of 18+18 places for the residential psychiatric care service ("Rehabilitation Centre"), with an additional 10 places allocated to the newly established Therapeutic Community for minors and young adults ("Il Soffio").

At the same time, the agreement with the Provincial Health Services Authority (APSS) was reinstated for a total of 16 places: 10 places within the "Il Soffio" Therapeutic Community and 6 places within the lower-intensity residential unit of the Rehabilitation Centre.

c. Codess Sociale

Codess Sociale is a Type A Social Cooperative, founded in Venice in 1979, operating throughout Italy in the social care, health and social care, and socio-educational sectors. As a mutual, non-profit organisation, its mission is to pursue the general interest of the community by promoting personal development and the social integration of citizens through the provision and management of social care, healthcare and educational services.

With experience working with more than 300 Public Authorities, **Codess Sociale** employs over 3,500 people throughout Italy.

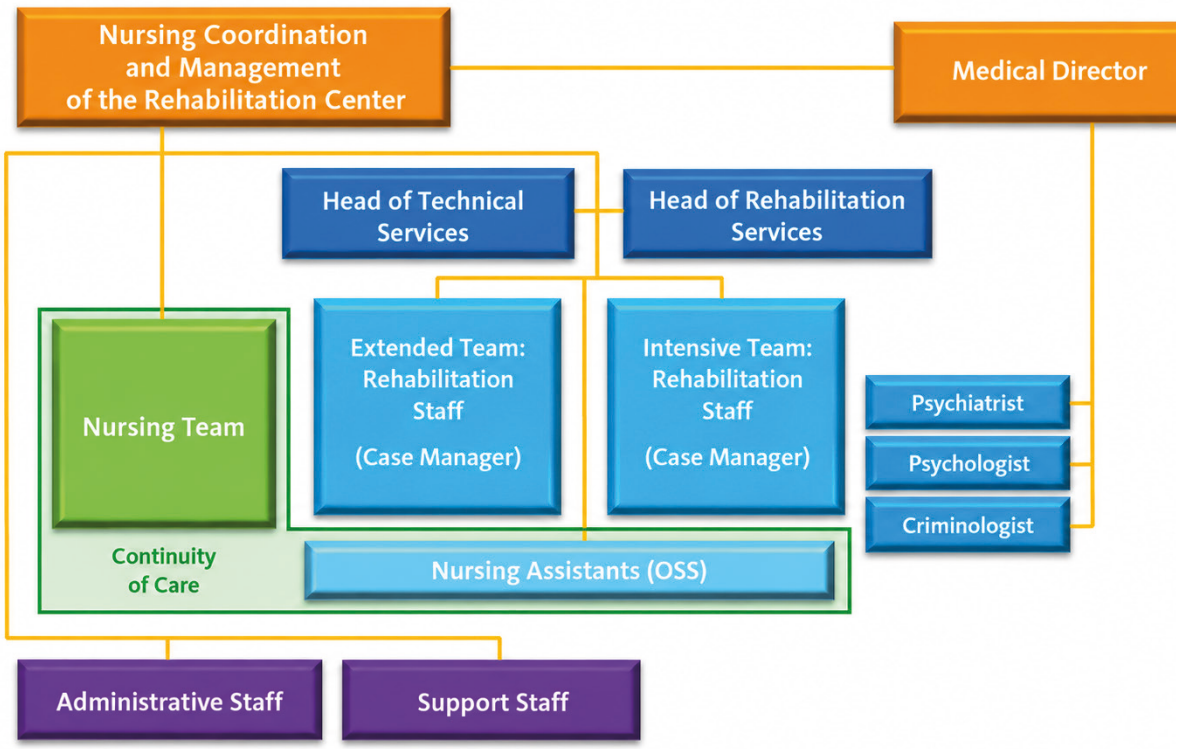
CODESS SOCIALE
SOCIETÀ COOPERATIVA SOCIALE

2.About Us

a. Our Team

The organisational model of the integrated Villa San Pietro facility is designed to promote the collaboration of professionals with different technical backgrounds.

Coordinators, nurses and healthcare assistants work across the various Rehabilitation Teams, each of which also includes a dedicated multidisciplinary team consisting of a Psychologist, Psychiatrist and Educators/Psychiatric Rehabilitation Technicians (TeRP), who act as Case Managers.



Below is a brief description of the main functions performed by the various professional roles at Villa San Pietro:

Medical Director: ensures the clinical appropriateness of interventions and the suitability of clinical procedures.

Rehabilitation Centre Coordinator: ensures and monitors the effective organisationaland operational management of the Rehabilitation Centre and its staff, defines work processes and promotes a positive and appropriate community environment.

Nursing Coordinator: organises nursing activities and schedules medical examinations and diagnostic tests.

Head of Rehabilitation Services: organises the work of the multidisciplinary team and ensures the appropriateness of Individualised Rehabilitation Plans.

Head of Technical Services: manages administrative aspects related to patient admissions and coordinates networking activities with Mental Health Services, court-appointed support administrators and, where applicable, representatives of the judicial authorities.

Psychiatrist: is responsible for monitoring patients' clinical condition and pharmacological treatment.

Psychologist: provides cognitive-behavioural psychotherapy interventions, both individually and in groups.

Criminologist: carries out criminological assessments and specific rehabilitation interventions for patients who have committed offences and have been admitted under judicial measures.

Nurse: is responsible for preparing and administering pharmacological treatments and ensuring continuity of care.

Psychiatric Rehabilitation Technician (TeRP): acts as Case Manager and conducts evidence-based rehabilitation activities according to standardised treatment models.

Educator: acts as Case Manager and conducts workshop-based, socialisation and recreational activities.

Healthcare Assistant (OSS): works with the rehabilitation team on activities relating to personal care and the management of living environments, and collaborates with the nursing team to ensure continuity of care.

Support Staff: are responsible for cleaning and sanitising communal areas.

Administrative Staff: support the Rehabilitation Centre Coordinator in carrying out administrative duties.

b. Mission and Vision

OUR VISION

"Bringing the world back to the patient, and the patient back to the world."

Villa San Pietro aims to support its residents through a process of social and vocational rehabilitation, with the goal of fostering integration within the local community. This approach is intended not only to help individuals regain skills within the facility, but above all to enable them to put those skills into practice in everyday social life.

Alongside the work carried out with each individual to help them reconnect with their social environment, Villa San Pietro also seeks to promote a broader cultural process within the local community, encouraging greater awareness and helping to reduce mistrust and prejudice towards people living with mental health conditions.

From this perspective, Villa San Pietro is not intended to be a facility focused exclusively on its residents, but also a place for meeting, exchange and integration between them and the wider local community.

OUR MISSION

Villa San Pietro's Mission can be summarised in two key points:

- **Recovery:** supporting patients in regaining a level of social and occupational functioning that enables them to resume an active, meaningful and personally fulfilling role upon returning to their social environment.
- **Reducing stigma:** overcoming the cultural barriers that contribute to mistrust and prejudice towards people living with mental health conditions.

c. Work With Us

"The most dangerous phrase of all is: "We've always done it this way.""
(Grace Murray Hopper)

Villa San Pietro aims to become a centre of excellence for the residential rehabilitation of patients with psychotic symptoms. To achieve this goal, the facility's Management is committed to recruiting highly qualified professionals who are motivated to contribute actively to the ongoing development and improvement of its working model.

We are committed to recognising and enhancing the value of both experienced professionals and younger, enthusiastic staff. Over the years, we are proud to have attracted several highly qualified professionals who chose to relocate from other parts of Italy, drawn by the enthusiasm and professional opportunities generated by the Villa San Pietro project.
We also have several agreements in place with educational and training institutions for professional internships at Villa San Pietro. These include the Degree Courses in Psychiatric Rehabilitation Techniques at the Universities of Verona (Rovereto campus) and Ferrara, several psychotherapy training schools in Verona, Brescia and Bolzano, and the Healthcare Assistant (OSS) Training School in Riva del Garda.

Anyone interested in collaborating with Villa San Pietro through an employment opportunity, a professional internship or volunteer activities may send their CV by email to **villasanpietro@codess.org**

3.How We Work

a. Evidenced-Based Psichiatry

To achieve its Vision and Mission, Villa San Pietro structures its activities around highly specialised clinical and organisational strategies, in line with the latest scientific evidence and with the organisational models adopted by leading centres specialising in the rehabilitation of psychiatric patients.

Our overall working methodology is inspired by the principles of Evidence-Based Medicine (EBM), defined as "the integration of the best available scientific evidence, clinical expertise and patient preferences" in clinical decision-making.

In practice, this translates into the following working methods:

- Selection of rehabilitation activities whose effectiveness is supported by scientific literature;
- Delivery of these activities according to standardised and reproducible protocols; Ongoing staff training in the implementation of the planned activities;
- Measurement of treatment outcome indicators at the beginning and at the end of the rehabilitation programme.

To complement and further enhance the evidence-based approach, the Villa San Pietro project aims to take an additional step forward by drawing on the principles of so-called **Value-Based Medicine (VBM)**, which has been defined as: "medical practice that, while grounded in Evidence-Based Medicine (EBM), extends its approach by incorporating, firstly, the value of interventions as perceived by the patient and, secondly, the cost-effectiveness of those interventions.".

b. A Recovery-Oriented System

At Villa San Pietro, patients are not merely passive observers of their rehabilitation pathway. On the contrary, they are encouraged to participate actively and responsibly in defining it. Together with the professionals involved in their care, each patient identifies the goals to be placed at the centre of their **Individualised Rehabilitation Plan (PRI).**

Once these goals have been defined, the patient and their designated professional work together through a process of "co-production" to assess which personal resources are already available and which need to be strengthened through specific rehabilitation strategies.

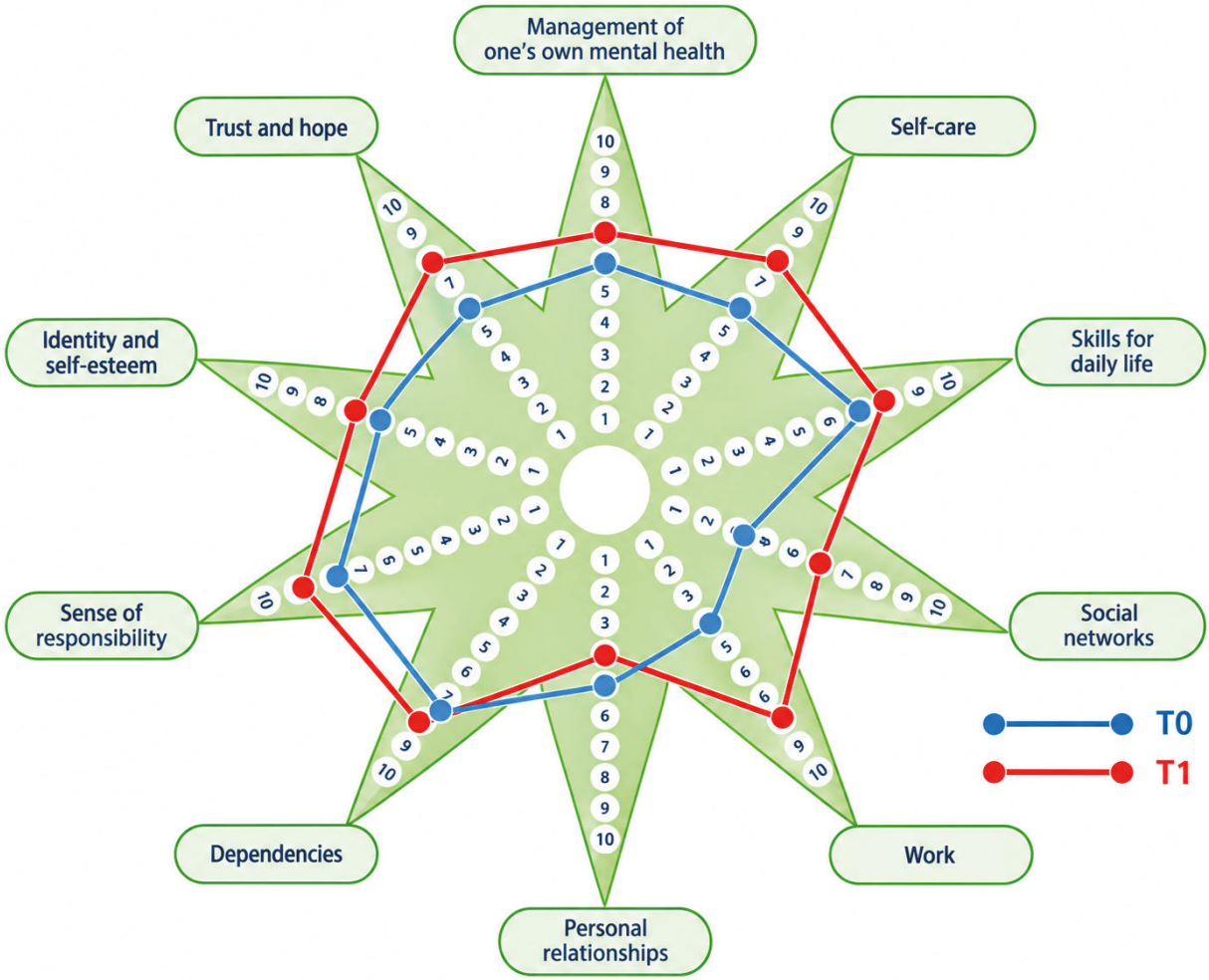
This process takes place within an organisational and relational framework based on the principles of mutual transparency, confidence in the possibility of change, and the patient's active responsibility for their own rehabilitation pathway.

To promote the effective co-production of the Individualised Rehabilitation Plan (PRI) by the patient and the professional, Villa San Pietro has adopted a dedicated tool called the **Mental Health Recovery Star™.** This is a multidimensional assessment scale completed by the patient together with their Case Manager during the first few weeks following admission.

The tool is subsequently used to assess progress and to adapt the individual rehabilitation plan according to the needs identified. This monitoring process also aims to provide the patient, professionals and referring Services with feedback on the outcomes achieved throughout the rehabilitation pathway.

The **Mental Health Recovery Star™** is a tool developed by © Triangle Consulting Social Enterprise (www.outcomesstar.org.uk), designed to support service users and their designated professionals in defining, monitoring and evaluating care and rehabilitation pathways based on the principles of recovery-oriented practice.

The theoretical framework underlying the Recovery Star is based on co-production, empowerment, the recognition and value of service users' lived experience, and the role of professionals in facilitating each individual's personal journey of change.



c. Case Management

Within each Rehabilitation Team, Educators and Psychiatric Rehabilitation Technicians (TeRP) act as Case Managers for a number of patients ranging from 4 to 6 per professional, depending on the intensity of the rehabilitation programme.

Assigning a Case Manager to each patient is a key element of the rehabilitation pathway. Its primary purpose is to ensure that the different rehabilitation interventions are coordinated effectively and that the various professionals involved in the patient's care work in an integrated manner.

The Case Manager is responsible for building an effective therapeutic alliance with the patient. This is an essential prerequisite for identifying, together with the patient, which specific components of the rehabilitation intervention should be used at each stage, so that the rehabilitation plan as a whole is effective in terms of outcomes, consistent with the patient's values, and well integrated within the broader care team.

Each Rehabilitation Team holds a weekly meeting to continuously monitor and review each patient's rehabilitation plan through discussion and the integration of contributions from the different professional disciplines involved.

d. Individualised Rehabilitation Plan

One of the main risks in psychiatric rehabilitation, particularly in residential settings, is failing to truly move beyond the care-based and custodial approaches that characterised psychiatry in the past. Even today, psychiatric residential facilities are still too often regarded as "containers" in which people with disabling psychiatric symptoms are placed for shorter or longer periods of time.

Objectives of admission	**1.** Strengthen self-esteem and reduce the need for external approval, by fostering the ability to integrate into functional social groups without resorting to dysfunctional behaviors; **2.** Reprocess life experiences related to previous trauma; **3.** Consolidate the ability to manage one's own symptoms; **4.** Prepare the patient for the future transition to a protected housing arrangement in their area of origin.
Type of residential program	☒ Extended (medium intensity) ☐ Intensive
Planned duration of admission	36 months (possibly extendable by a further 12 months)

Date: ____ / ____ / _____

Signature of a referring service professional _____

Patient's signature _____

Signature of the Medical Director _____

At Villa San Pietro, residential psychiatric care is instead conceived as a "f**orge for change**": a highly specialised centre in the field of psychiatric rehabilitation, where patients can benefit from a wide range of high-quality, intensive, evidence-based rehabilitation interventions.

For this reason, before admission, each patient is invited to work with their community care team and the professionals at Villa San Pietro to identify the goals they wish to pursue during their stay and the timeframe within which those goals can realistically be achieved. This pre-admission "agreement", recorded in the **Admission Proposal Assessment Form,** provides the framework for every rehabilitation pathway at Villa San Pietro, guiding the development of the Individualised Rehabilitation Plan (PRI) and its subsequent periodic reviews.

The PRI identifies the areas of intervention to be addressed at a given stage. Each area may include one or more goals and, for each goal, the corresponding rehabilitation strategies (**"SMART" actions**) and outcome assessment criteria are defined. At each review of the Individualised Rehabilitation Plan (PRI), generally carried out every 3–5 months, the results achieved are assessed and the goals and strategies for the next phase are redefined.

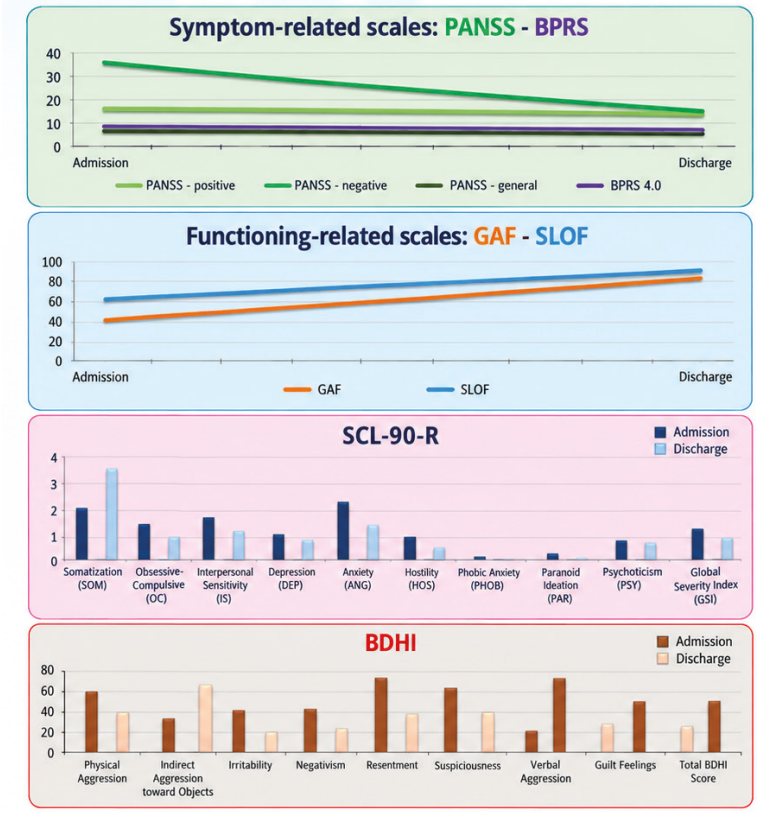
At the end of the residential rehabilitation programme, a detailed report is prepared for each of the goals identified at the time of admission, describing the SMART actions implemented and the corresponding outcomes (see example).

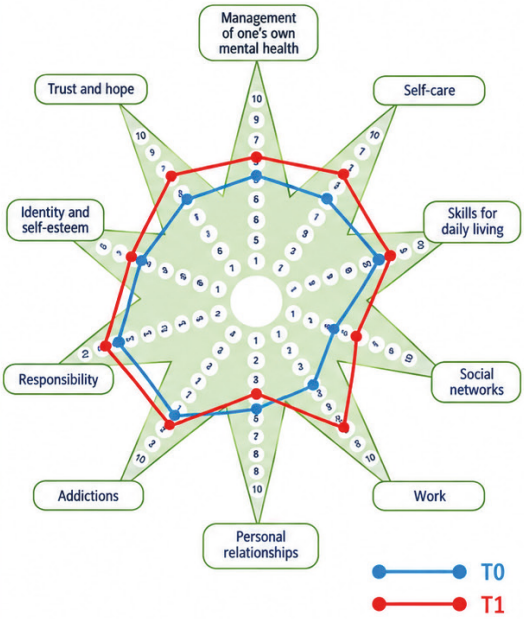
CLINICAL OUTCOME INDICATORS

	OBJECTIVE	OUTCOME	SMART ACTIONS AND OUTCOME INDICATORS
1	**Develop the ability to recognize, express and manage emotions in a functional way**	**Achieved**	During the stay at the VSP, the patient participated in a cognitive-behavioural psychotherapy program with weekly sessions. The patient has learned functional ways to manage emotions and express them appropriately, gaining specific benefits, for example, through the guided use of the "ABC" tool. Feedback from a family member, together with the stable therapeutic relationship with the service, has helped the patient to feel increasingly supported, further contributing to the development of self-awareness and the ability to manage emotions. The reduction of theatrical and self-isolating behaviours, initially frequent, represents an indirect indicator of the improvements achieved by the patient in relation to this rehabilitation goal.
2	**Prepare for the future by finding housing in a community setting and exploring possible job opportunities in the internal and external work environment**	**Achieved and exceeded**	The patient has benefited from inclusion in a rehabilitation context that supports her not only in times of difficulty, but also in building new capabilities. Through joint therapeutic-rehabilitation interventions, the patient has been able to overcome her fear of social situations, adopt alternative communication strategies, and engage in small daily challenges, ultimately finding the motivation to re-enter the workforce. The positive outcome of this process has strengthened her self-esteem and confidence in her own abilities, including the ability to take initiative. During the final months of her stay, the patient independently identified housing options in the local area and, with minimal support from the services, was able to activate an internship at a local bakery and find a suitable housing solution near her workplace.

Clinical assessment is complemented by the measurement of "objective" outcome indicators, based on the administration of psychometric scales. The results are then presented graphically in the discharge report. Finally, the overall evaluation of the rehabilitation programme is also provided by comparing the Recovery Star chart completed at the beginning of the residential stay with the one completed at discharge.

TEST-BASED OUTCOME INDICATORS





We believe that this way of working helps patients, their families and the professionals supporting them to recognise that the time and energy devoted to the residential rehabilitation programme serve a clear purpose and form part of a meaningful process of care and change.

e. Us and Others: Working as a Network

To support the effective reintegration of patients into social and working life, the rehabilitation pathway must combine training within the facility with equally intensive work aimed at interaction and integration with the local community, families and referring Services.

To ensure continuity between the rehabilitation pathway and the care provided by the referring Service, network meetings are generally organised every 3–5 months, in conjunction with reviews of the Individualised Rehabilitation Plan (PRI). These meetings involve all the professionals and individuals supporting the patient. In addition to the patient and the professionals from the Community Mental Health Centre (CSM) and Villa San Pietro, the meetings may also include, where appropriate, family members, the patient's court-appointed support administrator, lawyer and Social Services professionals. The matters discussed are subsequently recorded in formal minutes and shared with the Services

involved, highlighting the decisions taken, the professionals responsible for implementing them and the agreed timeframes.

The first of these meetings takes place before admission and is intended to promote mutual understanding, assess the patient's motivation to undertake a residential rehabilitation programme, and agree on the goals and expected duration of the placement. The final meeting provides an overall review of the rehabilitation pathway and is used to define the discharge plan.

Recognising the importance of involving families in the rehabilitation process, a specific psychoeducational intervention for family members may also be offered where appropriate, generally led by the team psychologists.

f. Training and Supervision

To achieve effective outcomes, a highly specialised rehabilitation programme such as the one offered by Villa San Pietro requires appropriately trained professionals. Providing specific and up-to-date training for the various professional roles involved is an ongoing commitment that Codess Sociale makes to its staff. This commitment currently includes the organisation of weekly training sessions for Villa San Pietro personnel, some of which are also open to external participants.

This initiative, which is particularly ambitious given both the frequency and the quality of the sessions, reflects our commitment to making Villa San Pietro a centre of excellence in the rehabilitation of psychiatric patients and is a source of particular pride for us.

Examples of the training programmes delivered to date include:

- Forensic Psychiatry (Dr Carlo Andrea Robotti)
- Recovery Star (Il Chiaro nel Bosco Association)
- Fundamentals of Psychopathology (Dr Damiano Pecile)
- Evidence-Based Psychiatry (Dr Alessandro Pompoli)
- Psychiatric Rehabilitation (Dr Alessandro Ricci)
- Management of Aggressive Patients (in collaboration with APSS and ULSS 9
- Clinical Case Discussions (Dr Alessandro Pompoli, Dr Fulvio Guccione)
- Adolescent Psychopathology (Dr Giuseppe Battaglia)
- Developing Rehabilitation Plans (Dr Alessandro Pompoli)
- Fundamentals of Neuropsychology (Dr Alice Beati)
- Supervision of the Multidisciplinary Team (Dr Alfredo Vivaldelli)

4. How to Access Our Services

a. Who We Serve

The period spent at Villa San Pietro should be understood as one phase within a broader and more complex care pathway coordinated by the Community Mental Health Services. Effective coordination with these Services is therefore essential, both to identify the patients who are most likely to benefit from the programme and to ensure continuity between the period spent at Villa San Pietro and the phases of care that precede and follow it.

Villa San Pietro's organisational model and rehabilitation services are specifically designed for the rehabilitation of patients experiencing psychotic symptoms, who represent the facility's primary target group. Patients with diagnoses relating to other areas of psychopathology are generally not admitted, as the rehabilitation services offered may be less appropriate for their needs. Exceptions to this general principle may be considered where the individual clinical situation suggests that the proposed interventions would nevertheless be suitable for the patient's specific needs.

For patients in a subacute phase, a high-intensity rehabilitation programme is generally recommended. An extended rehabilitation programme is more suitable for patients in a chronic phase and may be provided at either low or medium intensity.

Villa San Pietro is not, however, suitable for patients experiencing acute symptoms, for whom admission to an acute psychiatric inpatient unit (SPDC) would be more appropriate, or for patients in a chronic residual phase, for whom a setting focused less on rehabilitation and more on ongoing care and support would generally be more suitable.

The Rehabilitation Centre may also admit patients subject to judicial measures, such as probation or home detention, who may benefit from a dedicated rehabilitation programme. However, since Villa San Pietro is not a custodial facility and does not use coercive methods, admission requires the patient's willingness to enter the programme and the absence of a high risk of absconding or aggressive behaviour. Where such risks are considered significant, the admission request cannot be accepted.

The length of stay varies according to the individual case, up to a maximum of **18 months for intensive rehabilitation programmes and 3 years for extended rehabilitation programmes, i**n accordance with current legislation.

Below is a summary of the inclusion and exclusion criteria taken into consideration when assessing admission proposals:

INCLUSION CRITERIA

- Age over 18 years;
- Psychiatric disorder in a subacute or chronic phase;
- Patient's consent to admission to the facility;
- Availability of the referring Service to manage any possible acute exacerbations.

EXCLUSION CRITERIA

- Psychiatric disorder in an acute phase;
- High risk of aggression towards others or self-harm;
- High risk of breaching any security measures ordered by the judicial authorities;
- Active alcohol or substance use disorder;
- Disability resulting from intellectual impairment (IQ < 70);
- Personality disorder as the primary diagnosis;
- Insufficient knowledge of the Italian language.

b. How to Begin a Rehabilitation Programme

Admission to Villa San Pietro always takes place following a referral from a Community Mental Health Service; direct admissions from other organisations or private admissions are not available.

The first step generally consists of a telephone discussion between the professionals from the referring Service and the representatives of Villa San Pietro. For this purpose, the Medical Director or the Head of Technical Services may be contacted.

Once it has been confirmed that the patient meets the admission criteria, the referring Service is asked to provide a detailed clinical report presenting the case.

This report must include the following information:

- **Diagnostic assessment;**
- **Recent and past psychiatric history;**
- **Goals of the referral;**
- **Expected duration of the placement.**

Ideally, the referral report should also include:

- Any relevant physical health conditions;Family psychiatric history;
- Social and employment history;
- Judicial history;
- Medication history;
- Substance use history;
- Results of any relevant diagnostic investigations (ECG, EEG, CT scan, MRI, recent laboratory tests, etc.);
- Main family contact;
- Referring therapist/team;
- Any legal representative and/or court-appointed support administrator.

If, after reviewing the documentation provided, Villa San Pietro is considered potentially appropriate for the rehabilitation needs of the proposed patient, an in-person meeting is generally arranged at our facility. The patient is invited to visit Villa San Pietro accompanied by a professional from the referring Service and, where possible, by a family member.

This meeting provides an opportunity to present Villa San Pietro's rehabilitation services and to agree on the timing and goals of a possible admission. The patient is also given the Service Charter and the Rules of Conduct During the Stay. If the patient decides to begin a rehabilitation programme with us, they are also provided with a list of items to prepare before admission.

If there are no obstacles to admission, the patient is placed on the waiting list. Admission priority is determined according to predefined criteria, in the following order:

1. Urgency related to clinical factors;
2. Urgency related to judicial factors;
3. Urgency related to social factors;
4. Length of time on the waiting list;
5. Age, with priority given to younger patients.

When a place becomes available, the Head of Technical Services contacts the referring Service to agree on the admission date and requests that the Admission Proposal Assessment Form be signed by both the patient and a representative of the referring Service.

c. First Steps

Upon admission, the patient is welcomed by a member of the team, who accompanies them to their room and introduces them to the organisation of the facility. The patient is then assessed by the psychiatrist, who opens the electronic medical record, and by the Head of Rehabilitation Services.

From the very first days, the patient is introduced to the Individualised Rehabilitation Plan (PRI) that will guide the initial weeks of their stay. This plan includes the following four initial goals:

1. Complete the Recovery Star together with the Case Manager;
2. Further develop the patient's psychiatric history;
3. Begin carrying out assigned tasks, take part in outings and group activities, and share a room with another resident;
4. Comply with the facility's internal rules and the agreements made with the Case Manager.

During the first 4 weeks, the patient is invited to take part in a series of clinical and psychometric assessments, with the Mental Health Recovery Star playing a central role. The psychometric scales administered also include the BPRS, PANSS, GAF, SLOF, SCL-90 and BDHI.

Within 45 days of admission, the first review of the Individualised Rehabilitation Plan (PRI) is generally carried out, taking into account the progress made under the initial PRI, the recommendations of the referring Service, clinical observation, the results of the psychometric assessments and, importantly, the patient's own values. The review of the PRI involves the patient, their Case Manager, the Head of Rehabilitation Services, the team psychologist and the psychiatrist.

The rehabilitation programme then begins in full. The patient is invited to take part in individual and group rehabilitation activities, both within and outside the facility, according to a structured schedule. No two PRIs are the same: each patient is offered a specific combination of rehabilitation interventions tailored to their goals, personal resources and areas of difficulty.

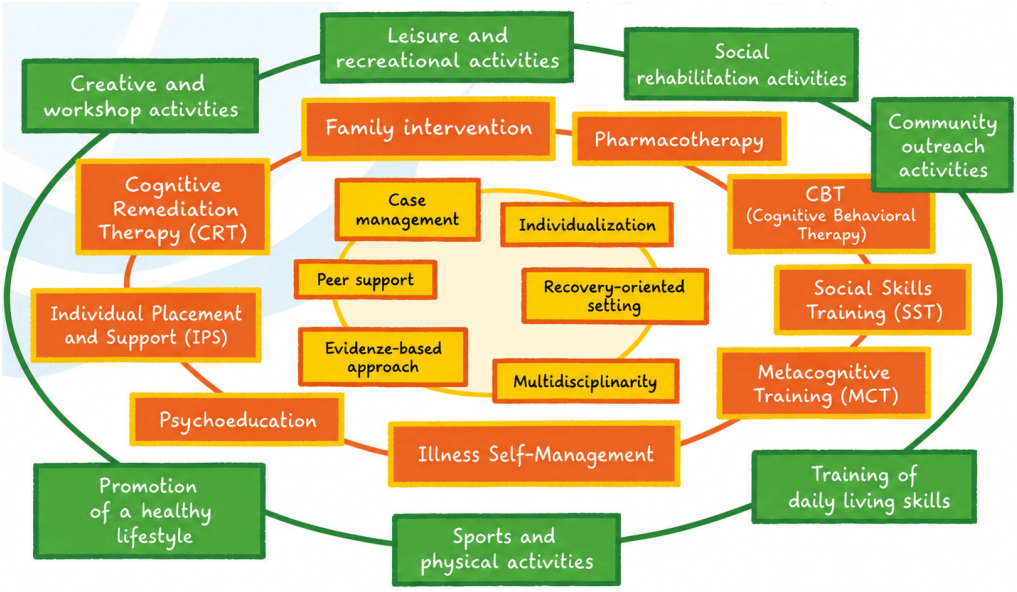
5. What We Offer

a. Rehabilitation Activities

Villa San Pietro's rehabilitation services are specifically designed for patients experiencing psychotic symptoms. The selection of rehabilitation activities, as well as the way in which the care environment is structured, is based on the principles of evidence-based psychiatry. This means that Villa San Pietro aims to make available to patients, and to the rehabilitation teams supporting them, all therapeutic and rehabilitation interventions whose effectiveness in the treatment of psychotic disorders has been demonstrated. Particular attention is paid to ensuring that these interventions are delivered appropriately and continuously updated in line with scientific evidence and identified clinical needs.

In our view, this is an essential step in moving away from residential care understood merely as a form of "containment" towards a model centred on the provision of meaningful therapeutic and rehabilitation "content". The image below summarises Villa San Pietro's rehabilitation services. In the central section, the yellow boxes indicate the evidence-based methods through which interventions are delivered. The orange boxes represent structured interventions with proven effectiveness in the treatment of patients with psychotic symptoms, which Villa San Pietro has therefore chosen to implement. Finally, the outer frame (green boxes) represents a range of interventions that are not specifically designed for patients with psychotic symptoms, but are considered useful in promoting basic independent living skills and creating a normalising and destigmatising environment.

FROM CONTAINMENT TO CONTENT
Activities for Patients with Psychotic Symptoms



Each rehabilitation intervention is based on careful planning aimed at defining its objectives, strategies, setting, target group, reference manuals and outcome indicators.

Group rehabilitation activities are organised according to a weekly schedule that is updated periodically. Each day includes both structured rehabilitation activities and workshop-based activities (see image). Each patient's participation in a specific combination of these activities is defined on a highly individualised basis within their Individualised Rehabilitation Plan (PRI).

WEEKLY SCHEDULE OF REHABILITATION ACTIVITIES

Weekly Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday and Sunday
7:00–8:30	Getting up, personal care and tidying the room					
8:30–9:00	Breakfast					
10:00–11:00	PSRR (Social Vulnerability and Risk of Relapse Prevention)	Social Skills Training Training for Daily Living Skills	Group "Discover your cards"	InteGRO	Cooking Group	Group outing
11:00–11:15	Break					
11:15–12:15	Psychoeducation	Creativity Workshop	Screen Printing Workshop	Problem Solving	Theatre Workshop	Group outing
12:30–14:30	Lunch break					
14:30–16:00	Physical Activity (cycling)	Physical Activity (gym)	Physical Activity (walking)	"CatFish" Group	Socialization Group	Group outing
16:00–16:30	Afternoon snack					
16:30–19:00	Outing / Free time					
19:00–19:30	Dinner					
19:30–23:30	Free time					

Since Villa San Pietro also admits patients who have committed offences, a dedicated package of interventions has been developed for these individuals to complement the standard rehabilitation programme. These interventions include:

- Management of the administrative and bureaucratic complexities associated with judicial measures;
- Individual sessions with the criminologist aimed at exploring the psychopathological dynamics underlying the offence;
- A structured group intervention consisting of three consecutive modules, respectively focused on psychoeducation in the criminological and forensic field, developing awareness of the offence, and fostering empathy towards the victim;
- Criminological assessment of the patient's profile and risk of reoffending, using the HCR-20V3 scale.

b. A Day at Villa San Pietro

The day begins for everyone with wake-up at 7:30 a.m. Breakfast is served at 8:30 a.m., leaving one hour for personal care and tidying one's room, with staff support where necessary.
At 9:00 a.m., patients take turns going to the area outside the nursing station to take their morning medication. Between 10:00 a.m. and 12:30 p.m., group rehabilitation activities take place according to a weekly schedule. Each patient takes part in a selected combination of these activities, as defined in their Individualised Rehabilitation Plan (PRI). When not engaged in group activities, patients take part in individual therapeutic and rehabilitation interventions (see image).

WEEKLY ACTIVITY SCHEDULE

Wöchentliche Planung	Montag	Dienstag	Mittwoch	Donnerstag	Freitag	Samstag und Sonntag
7:00–8:30	Getting up, personal care and tidying the room					
8:30–9:00	Breakfast					
9:00–10:00	Independent outing					
10:00–11:00	PSRR (Social Risk and Relapse Prevention)	Psychiatric consultation	Group "Discover your strengths"	InteGRO	Psychoeducation group	Group outing
11:00–11:15	Break					
11:15–12:15	Individual cooking	Creativity workshop	Screen printing workshop	Room cleaning and laundry	Individual psychotherapy	Free time
12:30–14:30	Lunch break					
14:30–16:00	Physical activity (cycling)	Rehabilitation meeting with the "Case Manager"	Physical activity (walking)	Small-sided football	Socialization group	Free time
16:00–16:30	Afternoon snack					
16:30–19:00	Outing / Free time					
19:00–19:30	Dinner					
19:30–23:30	Free time					

A short break and snack are provided in the middle of the morning, while lunch is served at 12:30 p.m. in a communal area.

Between 1:30 p.m. and 2:30 p.m., there are no structured activities, except on Fridays, when the weekly planning group takes place and involves all patients. On the other days, this time may be used to rest, pursue personal interests or attend individual meetings with the relevant professionals.

Afternoon activities begin at 2:30 p.m. and are generally less intensive than those held in the morning. From 4:15 p.m., following a short afternoon snack, patients may leave the facility to take part in sports or socialisation activities within the local community, as well as to make any necessary purchases.

Dinner is served at 7:00 p.m., followed by the administration of evening medication at 7:30 p.m. There are no structured activities afterwards, so patients may choose to return to their rooms, spend time with others or watch television.

Patients may not remain in the communal living area between midnight and 6:00 a.m. the following morning.

From the time of admission, each patient is included in the **daily task** rota and is assigned, on a rotating basis, a responsibility within the community (e.g. preparing breakfast, setting the table, etc.). This encourages active participation in the day-to-day functioning of Villa San Pietro and helps each patient feel like an active member of the group.

c. Relationships with the Local Community

To help overcome possible mistrust within the local community towards people with psychiatric conditions, Villa San Pietro promotes a range of initiatives aimed at bringing local residents and the facility's patients closer together. Initiatives carried out to date include hosting events open to the public within Villa San Pietro, such as physical activity courses for children and adults and book presentations, as well as encouraging patients to take part in local community events, such as Christmas markets.

For patients whose individual rehabilitation plan includes this objective, Villa San Pietro can also serve as a base for supported reintegration into education or employment, either within the local area or, where distance permits, in the patient's area of origin.

Villa San Pietro can also host conferences in its dedicated meeting room, which accommodates approximately 50 people. Its professionals are available to participate as speakers in training initiatives, both at conferences and within specific projects, thereby promoting the sharing of Villa San Pietro's working methodology within the Italian clinical and scientific community.

In addition, Villa San Pietro maintains links with university centres through collaborations aimed at staff training and professional development, as well as the implementation of research projects.

d. Other Services

In addition to rehabilitation activities, Villa San Pietro provides a range of services that complement its overall care and rehabilitation programme.

In particular:

Catering: Villa San Pietro has a professional kitchen, managed by external staff, where meals are prepared in accordance with the dietitian's recommendations and patients' preferences. Alternatives are available for each course, including for vegetarian patients and those with coeliac disease or food intolerances.

Laundry, ironing and wardrobe services: these include washing, changing and ironing household linen. Laundry activities for patients also take place within the facility as an integral part of the rehabilitation programme.

Cleaning and sanitisation: thorough daily cleaning is carried out, together with periodic deep sanitisation.

Gym: Villa San Pietro has a spacious gym for bodyweight exercises and aerobic activities, which may also host various types of courses open to the local community.

Garden: the facility is surrounded on three sides by a large private garden available to residents.

Money deposit service: safekeeping and management of small amounts of money according to arrangements agreed with the resident and, where applicable, their court-appointed support administrator.

Transport: residents are provided with transport to the nearest healthcare facilities when specialist medical appointments are required.

Safety system: every bed space and bathroom is equipped with an audible and visual call system that can be activated at the touch of a button, connecting residents with staffed areas.

Reception and administrative office: manages incoming calls and welcomes visitors. It also provides minor administrative support to residents upon request and ensures the delivery of their personal correspondence.

Medication: the costs of pharmacological treatments are largely covered by Villa San Pietro or by the Italian National Health Service (SSN), except in cases where the patient is required to contribute to the cost through the applicable co-payment.

e. Continuity of Care

Continuity of care is guaranteed 24 hours a day, 7 days a week, including public holidays, by nursing staff and healthcare assistants (OSS).

A psychiatrist is present at scheduled times, with at least three visits per week.

Upon admission, each patient is assigned to a local General Practitioner, who visits the facility once a month and, when necessary, can also see patients at their medical practice by appointment.

For the management of medical and psychiatric emergencies, Villa San Pietro refers to the Emergency Department in Arco, Trento.

6. Quality, Environmental and Social Responsibility Management Systems

Codess Sociale introduced its own Quality Management System in 2004 and, in February 2005, obtained **UNI EN ISO 9001:2008 certification** from the certification body UNITER.

In 2018, it adopted the new edition of the standard, obtaining **UNI EN ISO 9001:2015** certification, again through UNITER (Certificate No. 584).

Over the years, the adoption of various standards has led Codess Sociale towards an integrated management systems policy, together with the progressive updating of the standards applied and the related certifications.

The certifications currently held include **SA 8000:2014** (Certificate No. SA-184), issued by RINA and relating to social responsibility management; **ISO 14001:2015** (Certificate No. 70), issued by UNITER and relating to environmental management; UNI 10881:2013 (Certificate No. 084), also issued by UNITER and relating to residential care services for older people; and **UNI 11034:2003** (Certificate No. 085), relating to the management of early childhood education services.

Codess Sociale has also adopted an organisational and management model in accordance with the provisions of **Italian Legislative Decree No. 231/2001.**

The management systems are structured across three different levels:

1. **System Tools:** Documentation applicable across all Codess Sociale service areas, such as the Quality Manual, general procedures and certain standard forms used throughout the organisation.
2. **Area-Specific Tools:**Documentation specifically developed for the psychiatry area, but applicable across the various Codess Sociale facilities operating within this field. This documentation includes, for example, operational procedures, work instructions, standard forms, satisfaction questionnaires, job descriptions and any other tools designed to improve service delivery and enhance the quality of the services provided.
3. **Service-Specific Tools:**Developed within each individual facility according to its specific characteristics and needs.

The monitoring of Codess Sociale's management systems is carried out both centrally by the Quality Department, which works in close coordination with all Management, staff and operational areas, and internally by the designated personnel at Villa San Pietro.
The systems are also subject to further verification by external certification bodies.
The monitoring system adopted by Villa San Pietro consists of:

- Management of non-conformities and complaints;
- Management of adverse events;
- Assessment of internal and external customer satisfaction through questionnaires; Periodic team meetings;
- Monitoring of indicators in relation to established objectives;
- Risk reassessment and consequent updating of planned activities;
- Analysis of trends in the services provided by Villa San Pietro.

Process	Quality factors	Quality indicators	Quality standards
Admission assessment of new patients	Appropriateness of admission	Compliance with inclusion and exclusion criteria	Multidisciplinary verification of patient information; subsequent direct assessment of the patient
	Informed consent for admission by the patient	Patient's signature on the assessment form for the admission proposal	Provision of informative material; presentation of the facility to the patient during a preliminary meeting; joint signature of the patient, family members, referring service staff and Medical Director on the assessment form for the admission proposal
Reception	Dedicated welcome	Reception procedure	Support in the room by a team member; early preparation of the room with a personalised name label identifying the patient; presentation of the facility's organisation
	Clinical assessment at admission	Assessment and Reconciliation Form	Specialist psychiatric assessment within 24 hours of admission; completion of the Assessment and Reconciliation Form when the clinical record is opened
Stay	Individualised care planning	Case Management	Assignment of a Case Manager within the first week of admission
	Administration of assessment scales	Assessment scales (SCL-90R, BPRS, PANSS, GAF, SLOF, Recovery Star, etc.)	Administration of the assessment scales scheduled within the first month of admission
		Individualised Rehabilitation Project (IRP)	Co-production within 45 days of admission; review at least every 6 months
	Traceability of information related to the progress of the rehabilitation plan	Electronic clinical record	Recording of each rehabilitation activity carried out at group and individual level
	Regularity of psychiatric visits	Monitoring schedule for consultations	Access to a psychiatrist within the facility at least every 3 days per week
	Coordination with the referring service and key stakeholders	Meeting notes – network meeting minutes	At least one meeting every 6 months with the referring service and key stakeholders
	Flexible menu	Structured menu with variations upon request	Buffet-style breakfast; menu repetition every 4 weeks; different summer and winter menus; possibility of menu variations; availability of vegetarian options
Discharge	Information at discharge	Discharge letter	Delivery of the discharge letter to the patient and forwarding to the Case Management Service (CSM), including clinical, psychological and rehabilitative assessment, followed by outcome indicators and test results and useful strategies for the effective continuation of the rehabilitation plan
	Possibility of obtaining a copy of the clinical record	Days from receipt of the formal request to release the record	Delivery of a copy of the clinical record within and no later than 15 days
Quality	Reporting and management of adverse events (AE)	Statistics on reported adverse events (via electronic record); team meeting minutes	Immediate reporting of AEs in the electronic record; multidisciplinary discussion of adverse events and related management strategies during the weekly team meeting
	Reporting and management of non-conformities (NC)	Number of NC reports; claims register and NC; team meeting minutes for improvement actions	Immediate reporting of NCs in dedicated modules; multidisciplinary discussion of management strategies during team meetings for improvement actions
	Evaluation of service satisfaction by users, family members and referring services	Satisfaction questionnaire; register of complaints and NCs	Weekly group meeting between patients and staff to collect any complaints or suggestions; annual administration of a satisfaction questionnaire to users; recording of complaints/ suggestions from patients, family members or referring services
	Service delivery in accordance with appropriateness and uniformity principles	System, area and service procedures	Ongoing review and integration of internal procedures; presentation of more complex/ important procedures in dedicated and scheduled training sessions

7.Contacts

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