**Document 1: Step-by-Step Guide – How to Become an Accredited Social and Health Service Provider in Italy**

**Introduction**

In Italy, the accreditation of social and health services is under the jurisdiction of individual **Regions**, each establishing its own procedures and requirements. This guide specifically refers to the **Emilia-Romagna Region**, based on the regional legislation, particularly the Regional Council Resolution No. 514 of April 20, 2009, implementing Article 23 of Regional Law 4/2008 concerning the accreditation of social and health services. Accreditation is not just for residential centers but also for other activities related to people with disabilities, for example daily centers or home-based educational service.

1. **Preliminary Requirements**
   * Ensure that the service for which accreditation is sought has a valid authorization to operate, issued by the competent authority.
   * Verify that the service falls within the categories eligible for accreditation according to regional regulations.
2. **Preparation of Documentation**
   * Gather all required documentation, including:
     + Copy of the authorization to operate.
     + Descriptive report of the service offered.
     + List of employed personnel with relevant qualifications.
     + Adjustment plan, if necessary, to meet the required standards.
3. **Submission of Application**
   * Complete and submit the accreditation application to the Competent Institutional Body (Comune or Union of Municipalities) in the district where the service is located.
   * The application must be submitted within the deadlines established by current regulations.
4. **Evaluation of the Application**
   * The Competent Institutional Body reviews the submitted documentation and verifies compliance with the established requirements.
   * An on-site visit may be conducted to assess adherence to the required standards.
5. **Outcome of the Evaluation**
   * If the evaluation is positive, an accreditation certificate is issued.
   * If the evaluation is negative, the reasons are communicated, along with possible guidance for meeting the required standards.
6. **Monitoring and Periodic Verification**
   * Accredited services are subject to regular monitoring and verification to ensure ongoing compliance with requirements.
   * Any organizational or structural changes must be promptly communicated to the Competent Institutional Body.

**Document 2: Required Documents and Templates for Accreditation Application**

The Emilia-Romagna Region has provided specific forms for the accreditation application process. The accreditation process is quite complex and requires both general procedures and specific requirements depending on the individual services.

Below, as an attachment, you will find the list of general and specific requirements for the accreditation of residential facilities.

### **Specific Requirements for “Residential Structures and Units Dedicated to Individuals with Severe Acquired Disabilities under DGR 2068/04”**

### **INTRODUCTION**

In the case of admission of individuals with severe acquired disabilities (DGR 2068/04) to specific structures or units, the managing body must ensure an integrated management of these dedicated residential units. In addition to the general and specific requirements for residential facilities for the elderly and disabled, the following personnel, organizational/functional, and structural requirements must also be met. The access modalities to such residential solutions are defined by DGR 2068/04 and subsequent implementing acts.

### **DEFINITION**

These are specific socio-healthcare units for permanent or temporary admission, set up within other residential facilities for the elderly (nursing homes for non-self-sufficient elderly) or adults with disabilities (Residential Socio-Rehabilitative Centers), or within other types of structures.

Admission to units within facilities for people with disabilities preferably concerns cases such as spinal cord injuries or degenerative neurological diseases that do not present particular complexity (e.g., presence of tracheostomy tubes or mechanical ventilation).

### **PURPOSE**

* To provide long-term care programs at the conclusion of the rehabilitation process (care continuity);
* To promote and protect physical and mental well-being;
* To maintain optimal individual health conditions;
* To support the patient’s family;
* To maintain relationships with the social environment of origin and promote integration in the new residential context, enhancing the role of informal networks and associations;
* To offer temporary accommodation as respite care and/or support/training for families.

### **USERS**

People in a stabilized condition of very severe acquired disability, aged 18 or older, who have completed the rehabilitation process, with disabilities due to:

* **Severe brain injuries**, resulting from traumatic or other origins (e.g., cerebral hemorrhage, hypoxia/anoxia, encephalitis), which caused a state of coma, possibly prolonged, followed by permanent sensory, motor, cognitive, and behavioral disabilities, generally associated with a vegetative or minimally conscious state and resulting in total dependence.
* **Severe spinal cord injuries**, due to trauma or other causes, leading to severe tetraplegia with complete and permanent functional loss in all four limbs.
* **Severe disabling outcomes from advanced-stage degenerative neurological diseases** (e.g., ALS, Huntington’s disease). In these cases, reference should be made to advanced or terminal stage disabilities with total dependence and continuous need for care in self-care, mobility, and 24-hour supervision.

### **CAPACITY**

The unit should normally host between 6–8 and 15 residents, with a maximum of 30 residents (if 30, the unit must be divided into two sub-units).  
 Units within Residential Socio-Rehabilitative Centers for people with disabilities must have a minimum of 4–6 residents.

### **2. SERVICE OPERATIONAL PLANNING**

**2.1 Personnel** The service must employ adequately qualified healthcare and social-health personnel, as specified in Annex DB, with technical and relational skills suitable to meet the needs of individuals with severe acquired disabilities and support their families.

**2.2 Staffing and Assistance Standards**

* Daily presence of a **general practitioner**, typically 5 hours/week for every 5 residents (5 weekdays). For units with more than 10 residents, an additional 3 hours/week per 5 extra residents.
* Agreements and protocols must ensure:  
  + On-call GP during daytime hours
  + Coverage by out-of-hours medical services
  + Emergency services, via formalized protocols with the emergency department of the local health authority (AUSL)
* **Healthcare assistants (OSS)** must be present in a ratio of no less than 1 per 1.5 residents. There must always be at least two OSS during critical tasks like transfers, hygiene, dressing, feeding, etc.

**Other required roles:**

* **Unit coordinator** with healthcare coordination duties, carried out by nursing staff: 1 coordinator per 20 residents, with a minimum of 18 hours/week.
* **Nurses** must be present 24/7. For daytime activities, at least 1 nurse per 20 residents must be dedicated to the unit. For complex cases (e.g., tracheostomies, mechanical ventilation), additional nursing hours must be provided as per the Individual Care Plan (PAI).
* **1 physiotherapist per 20 residents**
* For spinal cord injuries and degenerative conditions: **1 educator or activities coordinator per 20 residents**
* **Psychologist**: 9 hours/week per 10 residents, for:  
  + Clinical activities for residents
  + Support for residents and families
  + Supervision and burn-out prevention for staff

**Social services**: The managing body must collaborate with local social workers.

### **2.3 Specialist Assistance**

The managing body must:

* Ensure a **medical reference** for the care team, including a physiatrist (for brain and spinal injuries) and a neurologist (for degenerative diseases), in collaboration with AUSL.
* Activate **formalized, multidisciplinary protocols** for:  
  + Access to specialist consultations (e.g., physiatrist, neurologist, pulmonologist, ENT, dermatologist, nutritionist, dentist, anesthesiologist)
  + Facilitated access to diagnostic and lab tests

### **Organizational and Management Requirements**

The managing body must ensure:

* Regular evaluation, planning, and documentation meetings (at least monthly)
* Procedures for developing **Individual Care Plans (PAI)** based on multidimensional, multidisciplinary assessments with indicators for:  
  + Prevention of complications
  + Physical and psychological well-being of residents and families
  + Family satisfaction and support of family-resident relationships
* Qualified assessment of **assistive technologies**, including external expertise if needed
* Visibility of PAIs to all staff; optional unified system for daily updates and PAI modifications
* Possibility for **family members to eat meals** inside the facility, provided by the structure
* Strategies to **maintain external social relations**, including partnerships with volunteer associations
* Visitor access for relatives and acquaintances; any restrictions must be included in the service charter or regulations and be minimal, respecting residents’ needs

### **3. COMMUNICATION, TRANSPARENCY, PARTICIPATION**

**3.1** Daily life and activities must reflect a typical family environment and ensure the highest possible level of resident participation.  
 **3.2** Family members must be allowed to eat meals provided by the facility within the structure.

### **Housing groups: Requirements and Start-Up Procedures**

Unlike residential facilities, **group homes** are **not subject to a formal accreditation process**, but certain **requirements must be met**.

### **Requirements for the Operator:**

* Must **not** have been declared a habitual, professional, or repeat offender.
* Must **not** have been convicted of non-negligent crimes with a custodial sentence of **no less than three years**.
* Must **not** have been convicted of crimes under **Book II, Titles V, VI, IX, XI, XII, XIII** of the Italian Penal Code.
* Must **not** be subject to preventive measures.
* The prohibition remains in effect for **five years** from the completion of the sentence or the final judgment, unless rehabilitation has been granted.

### **Requirements for the Building:**

* Must be designed to ensure **privacy and well-being** for the residents.
* **Single rooms** must be at least **9 square meters**; **double rooms** must be at least **14 square meters**.
* **Common areas** (e.g., kitchen, living room) must be at least **20 square meters**.
* Must meet the **needs of the users**, such as the **elimination of architectural barriers**, **appropriate microclimatic conditions**, etc.
* Must be equipped with all **essential services**, including a kitchen, bathroom, and toilet facilities.

### **Start-Up Procedures:**

* Submit a **SCIA** (*Certified Notice of Commencement of Activity*) to the local municipality.
* Ensure the building complies with all **structural and safety requirements**.
* Ensure the availability of **qualified personnel**.
* Register with the **regional or municipal list** of group homes (if required).
* Notify the **local authority** about the **availability of places**.