ASL Frosinone

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Service Charter

COMMUNITY HOSPITAL PONTECORVO
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1. THE OSPEDALE DI COMUNITÀ

The Ospedale di Comunità - OdC - Community Hospital of Pontecorvo - is a low-intensity clinical inpatient facility integrated into the local healthcare network. It is intended for individuals whore quire a period of continuous health assistance and clinical monitoring that can not be safely managedat home, but for whom admission to an acute care hospital is not appropriate.
The OdC performs an intermediate care function and supports the continuity of care by promoting clinical stabilization, functional recovery, and the management of post-acute pathways. Admission is temporary and oriented toward achieving defined health care goals, with particolar attention to discharge planning and coordination with local services. Assistance is provided according to an organizational model primarily managed by nursing staff, with scheduled medical responsibility through the integrated work of a multi-professional team in collaboration with General Practitioners, the local network, and, where necessary, acute care hospital facilities.
Basedon the territorial affiliation matrix of the Frosinone Local Health Authority, the community hospital of Pontecorvo, in the central southern geographical area is primarily intended to serve the population of the Cassino - Pontecorvo district by accepting patients discharged from, namely tha Santa Scolastica hospital in Cassino as well as from other hospitals in the province.
The community hospital is equipe with the standard 20 beds.

1.1. WHAT THE USER CAN EXPECT

During the stay, the patient and their family can expect:

- care management focused on safety and recovery;
- a defined care pathway, up-to-date an based on clinical evolution;
- attention to dignity, communication, and involvement in care decisions;
- Discharge planning and coordination with local services to guarantee the continuity of care.

2. USERS TYPES AND ELEGIBILITY CRITERIA

2.1. USER TYPES

The Ospedale di Comunità is intended for adults who present stabilized clinical conditions or conditions in the process of stabilization, for whom a period of low clinical intensity health recovery is necessary, which is not appropriate for admission to an acute care hospital and cannot be safely managed at home.
Users of the Community Hospital include, in particular, people who need:

- continuous clinical and healthcare monitoring;
- completion of an existing diagnostic-therapeutic pathway;
- functional recovery or reactivation after an acute event;
- temporary care support in the post-acute phase;
- preparation for discharge to the patient's home or to other local healthcare settings.

The Ospedale di Comunità welcomes patients coming from their home, acute care hospital facilities, or local services, according to scheduled and appropriate procedures.

2.2. ELEGIBILITY CRITERIA FOR ADMISSION

The admission to the OdC is appropriate for patients who present eligibility criteria consistent with the function of the facility and with the local care model.
In particular, the eligible patients:

- do not require high-intensity diagnostic or therapeutic interventions;
- do not present clinical instability such as to require admission to an acute care hospital;
- require continuous healthcare and clinical-care supervision;
- present care needs that cannot be adequately met at home during that phase of the care pathway.

Eligibility for admission is based on the patient's clinical, care, and functional conditions, in compliance with the appropriateness criteria and safety of care

2.3. ELEGIBILITY ASSESSMENT PROCEDURES

The assessment of eligibility for admission to an Ospedale di Comunità is carried out through a multidimensional clinical-care assessment, aimed at verifying that the care needs are consistent with the facility's objectives.
The assessment is performed in coordination with:

- General Practitioners;
- local health services;
- acute care hospital facilities;
- the Centrale Operativa Territoriale – (COT) Territorial Operations Center, where applicable.

The access to admission is planned and integrated into a shared care pathway, oriented towards continuity of care and subsequent protected discharge.

2.4. APPROPRIATENESS CRITERIA

The admission to an OdC is not considered appropriate for patients who:

- require intensive or sub-intensive care;
- present acute clinical instability;
- require high-complexity specialist interventions or invasive procedures;
- require exclusively social or hospitality assistance.

In such cases, the patient is directed toward the most appropriate care setting, in accordance with the identified clinical and care needs.

2.5. ADMISSION PROCEDURES

The duration of stay in an OdC is temporary and is defined in relation to the clinical and care objectives established in the Piano Assistenziale Individualizzato - Individualized Care Plan. The stay in the facility is aimed at achieving stabilization, recovery, and continuity of care objectives, while respecting the principles of appropriateness and safety of care.

3. ACCESS PROCEDURES TO THE OSPEDALE DI COMUNITÀ

3.1. GENERAL ACCESS PRINCIPLES

The access to the Ospedale di Comunità takes place according to scheduled and appropriate procedures, in consistency with the facility's function as a low clinical intensity health recovery and continuity of care center. The admission is aimed at managing patients who are clinically stabilized or in the stabilization phase and is part of a shared care pathway oriented towards continuity of care and subsequent protected discharge. The OdC does not represent a direct access point for emergencies and does not replace the Emergency Room or hospital facilities for acute patients.

3.2. LOCAL AREA ACCESS

The access to the OdC can occur from the territory, upon the proposal of General Practitioners or competent local services, following an evaluation of the clinical-care appropriateness of the admission. This modality of access is aimed at ensuring continuity of care for patients who require a period of health assistance that cannot be managed at home, in the absence of criteria for acute patient admission. The access from the territory is scheduled and integrated into a shared care pathway.

3.3. ACCESS FROM ACUTE CARE FACILITIES

The Ospedale di Comunità welcomes patients coming from hospital facilities for acute patients, following a protected discharge or scheduled transfer, when further high clinical intensity treatments are no longer appropriate, while the need for continuous health assistance remains.

This access modality promotes:

- the reduction of hospital stays for acute patients;
- the continuity of the treatment pathway;
- a safe assistance transition towards the home or other local settings.

3.4. ACCESS ASSESSMENT AND PLANNING

The access to the Community Hospital is subject to a clinical-care evaluation aimed at verifying the consistency of the patient's needs with the goals of the facility.

The evaluation is carried out in agreement with:

- General Practitioners;
- local services;
- hospital facilities for acute patients;
- the Centrale Operativa Territoriale (COT) - Territorial Operations Center.

The planning of access takes into account the patient's clinical, assistance, and functional conditions and the defined assistance goals.

3.5. CONTINUITY OF CARE AND COORDINATION BETWEEN SEVICES

The modalities of access to the OdC are integrated within the network of local and hospital services, in order to guarantee appropriate, safe, and continuous assistance pathways. The coordination between the various services involved ensures consistent management right from the access phase, favoring coordinated management of the hospital stay and subsequent discharge.

4. CLINICAL AND CARE MANAGEMENT DURING THE HOSPITAL STAY

4.1. ADMISSION MANAGEMENT

Upon admission to the Ospedale di Comuntà, the hospitalized person undergoes a structured clinical-care intake, aimed at guaranteeing appropriate, safe assistance that is consistent with the goals of the admission.

The admission occurs through an initial clinical, care, and functional assessment oriented towards:
- defining the person's health status;
- identifying priority care needs;
- establishing the objectives of the hospital stay;
- planning care and treatment activities.

4.2. PIANO ASSISTENZIALE INDIVIDUALIZZATO (PAI) – INDIVIDUAL CARE PLAN

Based on the initial assessment, the Piano Assistanziale Individuaizzato (PAI) - Individualized Care Plan - is defined, representing the reference tool for the hospital stay management.
The PAI:
- is shared by the multi-professional team;
- is consistent with the person's clinical and care conditions;
- is oriented towards clinical stabilization, functional recovery, and preparation for discharge;
- is updated in relation to the evolution of the clinical-care status.

The PAI guarantees a personalized and integrated approach to the care of the hospitalized person.

4.3. CLINICAL AND CARE MANAGEMENT OF THE HOSPITAL STAY

During the stay, care is provided according to an organizational model primarily managed by nursing staff, with scheduled medical responsibility, in compliance with professional competencies and current regulations.
Clinical-care management is aimed at:
- guaranteeing continuous clinical supervision;
- implementing the care interventions provided for by the PAI;
- preventing complications and clinical deterioration;
- promoting the recovery of residual autonomy;
- ensuring the safety of care.

Assistance is person-centered in its entirety, with attention to clinical, care, and relational aspects.

4.4. DUTIES OF THE MULTI-PROFESSIONAL TEAM

Care management during hospitalization is guaranteed by the coordinated work of the multi-professional team, which operates in an integrated and collaborative manner.

The team contributes:

- to the continuous assessment of health conditions;
- to the revision of the Piano Assistenziale Individualizzato;
- to the definition of discharge strategies and continuity of care.

Teamwork promotes a global and shared approach to the management of the care pathway.

4.5. INVOLVEMENT OF THE USER AND FAMILY

During hospitalization, the admitted person is adequately informed about their care pathway in compliance with the principles of clear information, informed consent, and participation. Depending on clinical and organizational conditions, the involvement of the family or reference persons is encouraged, in order to:

- support the care pathway;
- promote continuity of care at the time of discharge;
- promote a shared and conscious management of care.

4.6. MONITORING AND RE-ASSESSMENT OF THE CARE PATHWAY

Clinical and assistance management during hospitalization is subject to continuous monitoring and re-assesment relation to the evolution of the person's health conditions.
Re-assessments allow to:

- verify the achievement of care objectives;
- adjust the Piano Assistenziale Individualizzato;
- appropriately plan the discharge and the connection with local territorial services.

5. CONTINUITY OF CARE, PROTECTED DISCHARGE AND TRANSITIONAL CARE

5.1. CONTINUITY OF CARE

The Ospedale di Comunità Operates to guarantee continuity of care throughout the person's entire treatment path, ensuring the connection between the inpatient phase and the relevant local health services.
Continuity of care is pursued through:

- integration with General Practitioners;
- connection with the Case della Comunità;
- involvement of local and home care services;
- collaboration with the Centrale Operativa Territoriale (COT), where applicable.

Such integration allows for the assurance of care pathways that are coherent, appropriate, and oriented towards the safety of care.

5.2. TRANSITIONAL CARE

The OdC performs a transitional care function, understood as the structured management of a person's transition between different care settings.
Transitional care is aimed at:

- fostering a safe transition from acute care hospitals to local health care;
- reducing the risk of flare-ups and inappropriate readmissions;
- guaranteeing the continuity of care during the transition between hospitalization and home or other care settings.

Through transitional care, the OdC to a coordinated and progressive management of the person, in line with the identified care needs.

5.3. DISCHARGE PLANNING

Discharge from the Community Hospital is planned from the moment of admission and is an integral part of the care pathway.
Discharge planning is based on:

- an updated clinical-nursing assessment;
- objectives defined in the Piano Assistenziale Individualizzato;
- safety conditions for returning home or for transfer to other services.

Discharge takes place in a planned and shared manner, respecting the principles of appropriateness and continuity of care.

5.4. PROTECTED DISCHARGE

Protected discharge is activated when the person requires organized care support at the end of their hospitalization.
In such cases, the Ospedale di Comunità ensures coordination with:

- relevant local services;
- the Assistenza Domiciliare Integrata (ADI);
- any social-health facilities or services involved;
- General Practitioners.

Protected discharge facilitates the continuation of appropriate and safe care, reducing the risk of interruptions in care.

5.5. INVOLVEMENT OF THE LOCAL NETWORK

Continuity of care and protected discharge are achieved through the involvement of the local network, while respecting the skills and responsibilities of the various services.
The connection between the Community Hospital and local social and health services allows for:

- guaranteeing coherent management of the patient;
- fostering continuity of care;
- supporting the patient's return to their own living environment.

5.6. INFORMATION E SUPPORT TO THE PATIENT AND FAMILY

During the discharge and care transition process, the hospitalized person and, where appropriate, the family or caregivers are adequately informed about the methods for continuing care.
Information is aimed at:

- fostering awareness of the care pathway;
- supporting continuity of care;
- promoting active and responsible participation.

6. PROVIDED SERVICES AND PERFORMANCES

6.1. NURSING CARE

The Ospedale di Comunità guarantees continuous nursing care as a central element of the facility's organizational model.
Nursing care is aimed at:

- clinical and care surveillance of the hospitalized person;
- implementation of the interventions provided for in the Piano Assistenziale Individualizzato;
- prevention of complications;
- support for the patient and family;
- promotion of residual autonomy and functional recovery.

Nursing activities are carried out in compliance with professional competencies and best care practices, with attention to the safety of care.

6.2. SCHEDULED MEDICAL ASSISTANCE

The OdC ensures medical assistance according to a model of planned medical responsibility, in coherence with the facility's function as a low-intensity inpatient setting. Medical assistance is oriented towards:

- clinical evaluation of the patient;
- definition and monitoring of the treatment path;
- support for clinical-care management during the hospital stay;
- planning of discharge and continuity of care.

Medical activity integrates with nursing care and the work of the multi-professional team.

6.3. REHABILITATION AND FUNCTIONAL RECOVERY ACTIVITIES

Within the scope of the hospital stay, the OdC promotes support activities for functional recovery, consistent with the care objectives defined in the Piano Assistenziale Individualizzato.
These activities are aimed at:

- maintaining or improving functional capacities;
- preventing functional decline related to immobility;
- favoring the return at home or the transition to other care settings.

Rehabilitation activities are part of the overall process of the patient's management.

6.4. ESSENTIAL DIAGNOSTIC SUPPORT

The OdC guarantees access to essential diagnostic support services necessary for clinical monitoring and the management of the care pathway, in coordination with the relevant corporate

services. Diagnostic services are used appropriately and consistently with the facility's objectives, without overlapping with the specific activities of acute care hospitals.

6.5. CARE SUPPORT AND HOSPITALITY SERVICES

During the stay, the OdC ensures the support activities necessary for the well-being and safety of the inpatient, respecting their dignity and individual needs. These activities contribute to creating an appropriate, person-oriented care environment.

6.6. INTEGRATION OF SERVICES WITHIN THE CARE PATHWAY

All services and benefits provided by the OdC are integrated within a unified care pathway, oriented toward the goals of the PAI. The integration between nursing care, medical assistance, support activities, and coordination with local territorial services ensures appropriateness, continuity, and quality of care.

6.7. ORGANIC ENDOWEMENT

The Community Hospital of Pontecorvo has the following staffing:

- A Coordinator of General Practitioners;
- General Practitioners who takes turns providing care for six hours a day;
- A Nursing Coordinator;
- 6 Nurses;
- 6 Health Care Workers;
- A Physiotherapist .

7. INFORMATION, CONSENT AND PARTECIPATION

7.1. INFORMATION FOR THE IN PATIENT

The Ospedale di Comunità guarantees the inpatient the right to receive complete, clear, and understandable information regarding their state of health, the care pathway, the treatment methods, and the objectives of the hospitalization. Information is provided with respect for the person's clinical condition, their capacity for understanding, and current regulatory provisions, promoting communication that is adequate and respectful of the person's dignity. The OdC promotes a care relationship based on trust, listening, and transparency, as an essential prerequisite for appropriate and safe management.

7.2. INFORMED CONSENT

Informed consent represents a fundamental prerequisite of the care relationship and is acquired in compliance with the principles established by current legislation. The inpatient has the right to express their consent or dissent to care proposals after receiving adequate, updated, and understandable information.

Informed consent is:

- personal and free;
- specific and conscious;
- revocable at any time.

In the event that the person is unable to express consent, reference is made to the procedures provided by law for the involvement of a legal representative or trusted persons, respecting the patient's wishes and rights.

7.3. PARTECIPATION IN CATRE PATHWAY

The OdC recognizes and promotes the active participation of the inpatient in their own care pathway, in compliance with clinical and care conditions.
Participation is achieved through:

- the involvement in decisions regarding the care pathway;
- sharing of care objectives;
- continuous dialogue with the healthcare team

Informed participation encourages better adherence to the care pathway and contributes to the quality and safety of care.

7.4. INVOLVEMENT OF THE FAMILY AND CAREGIVES

Depending on clinical and organizational conditions, the OdC encourages the involvement of the family or caregivers as support for the care pathway and continuity of care. The involvement of the family occurs in respect of the patient's wishes, privacy protection regulations, and clinical-care indications.

7.5. PROTECTION OF DIGNITY AND RESPECT FOR THE PATIENT

In all phases of hospitalization, the Ospedale ensures respect for the dignity, values, beliefs, and choices of the patient. Care is provided in respect of the principles of humanization of care, guaranteeing attention to the person as a whole and promoting a welcoming and respectful care environment.

8. ACCESS TIMES TO DOCUMENTATION

8.1. HOW TO REQUEST CLINICAL AND SOCIAL ASSISTANCE DOCUMENTATION

The Anagni Community House clinical and social care records are released within 30 days of the application submission date, except in special cases where reports are pending. Current regulations require the facility to make existing documents available within 7 days of the request.

8.1.1. Procedure and Access Times at the Frosinone Local Health Authority

For patients discharged from the Community House, the application process involves specific steps and timeframes:

- **Processing times:** the medical record is made available within 30 days of the discharge date or the request.
- **Online (Recommended):** you can request, pay (from the second request onwards), and download the documents directly from home via the Frosinone Local Health Authority Online Help Desk. Access is via SPID.
- **In-person mode:** The request can be made by the patient himself or his delegate (provided with a proxy along with the delegating party's identification document) by contacting the Protocol Office of the Health District.

HOW TO REACH US

Getting to the Ospedale di Comunità di Pontecorvo is easy, whether yoy choose to travel by car or public tran sport.
Pontecorvo is about 35 Km from Frosinone and the Ospedale di Comunità is in Via San Giovanni Battista, 5.

By car:

- from **Frosinone and Rome**: take the A1 Autostrada del Sole towards Naples and exit at the Pontecorvo Castrocielo toll booth. From here, follow the signs for the city center, approximately 10 minutes'drive.
- From **Naples** take the A1 Autostrada northwards always exit at Pontecorvo - Castrocielo and follow the local road system, Strada Statale 6 Casilina.

By pubblic transport: there is no direct train station in the center of Pontecorvo; the best options are to use a combination of train and bus.

- By **train**: the most convenient and well - served stations are Roccasecca or Cassino along the Rome - Naples regional line.
- By **public bus**: from the Roccascca or Cassino stations you can take a Cotral bus that will take you directly to the centre of Pontecorvo in about 20 - 30 minutes. You can monitor timetables in real time via the Cotral timetables and routes portal.

This Service Charter represents the organization of the services offered within the facility at the time of its publication and is subject to periodic review of its contents