



# **INTERREG ITALY-CROATIA PROJECT ADRINCLUSIVE**

## **Output 02.1**

**ADRINCLUSIVE Action  
plan for improving the competences of  
tourism and welfare operators in the IT-  
HR area**

**(Version 1.0 – 28/02/2026)**

<b>Project Title</b>	<b>Innovative and sustainable tourism offer for equal access and social inclusion of people with dementia and cognitive decline to tourist destinations in the Adriatic Sea</b>
<b>Project Acronym</b>	<b>ADRINCLUSIVE</b>
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<b>Output</b>	<b>O2.1 ADRINCLUSIVE Action plan for improving the competences of tourism and welfare operators in the IT-HR area</b>
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## 1. Introduction and strategic rationale

### 1.1 Scope of the Action Plan

This Action Plan is the operational translation of the ADRINCLUSIVE cross-border training methodology (D2.3.1) into a replicable framework for capacity building in dementia-friendly tourism across the Italy-Croatia programme area, after acquiring the results of the piloting as reported in D2.4.1.

It is not a training manual — that role belongs to D2.3.1 — but rather the bridge between methodology and implementation: the document that defines who needs to be trained, on what, with which tools, under what conditions, and to what measurable standard.

The need for such a bridge was established by the territorial analysis conducted under WP1. The stakeholder mapping and needs assessment report (D1.2.1) revealed a tourism sector that is willing but profoundly unprepared: the primary barrier to inclusive hospitality for people with dementia is not architectural, but a widespread lack of knowledge about what dementia actually is, which translates into operational anxiety among frontline staff. In the absence of structured training, operators rely on intuition when encountering guests with cognitive difficulties, with the constant risk of inadvertently increasing disorientation and distress. This Action Plan intervenes precisely at that gap, providing a structured intervention model that replaces uncertainty with protocol, and improvisation with professional competence.

The ultimate objective is to define a replicable intervention framework that accounts for the specificities of the tourism sector in Italy and Croatia — its seasonal rhythms, its mix of small operators and larger hospitality chains, its reliance on a workforce that spans front-desk staff, housekeepers, tour guides, restaurant managers, and welfare professionals — while standardising the quality of welcome for people with dementia and their caregivers across the Adriatic area.

### 1.2 Inclusive tourism as a non-pharmacological intervention

The scientific rationale underpinning this plan draws on positive psychology and the growing body of evidence identifying well-designed travel experiences as a non-pharmacological intervention of considerable value for people living with dementia. A properly organised holiday acts on multiple levels simultaneously. For the guest, it counters the social withdrawal and apathy that commonly follow diagnosis, providing new environmental stimuli that help sustain the identity of "traveller" rather than "patient." For the caregiver, it functions as structured respite care, reducing the constant burden of assistance and the fear of the unexpected through the presence of specifically trained staff and adapted facilities. This framing — the holiday as a "meaningful experience" capable of generating positive emotions that persist well beyond the duration of the stay — is central to the ADRINCLUSIVE model and distinguishes it from a purely accessibility-oriented approach.

## 2. Context analysis: needs, barriers, and territorial specificities

### 2.1 The role of the environment in cognitive well-being

The analysis conducted through the methodology development process (D2.3.1) established that the physical environment often acts as a silent "disabler." The critical issues are not limited to the absence of ramps or lifts — they extend into the sensory and cognitive sphere. Environments that are too noisy, poorly lit, or characterised by strong contrasts (typical of wellness areas, lounge bars, or large dining halls) can trigger sensory overload that leads to episodes of agitation. Floor surfaces with complex geometric patterns or excessive chromatic contrasts represent a specific risk: a person with dementia may perceive these as physical obstacles or holes in the ground. Signage must be high-contrast, positioned at eye level, and supplemented by the creation of "quiet spaces" — decompression zones where the individual can regain calm and a sense of orientation.

### 2.2 Cross-border comparison: Italy vs Croatia

The comparative analysis between the Italian and Croatian territories reveals complementary challenges requiring differentiated responses. In Italy (particularly the Marche and Emilia-Romagna regions), there is strong individual motivation and a long tradition of social tourism, but this tradition struggles to translate into standardised professional protocols for the private hospitality sector. In Croatia, the presence of modern hotel chains provides an excellent infrastructural base, but there is a marked distance between the travel industry and the welfare system.

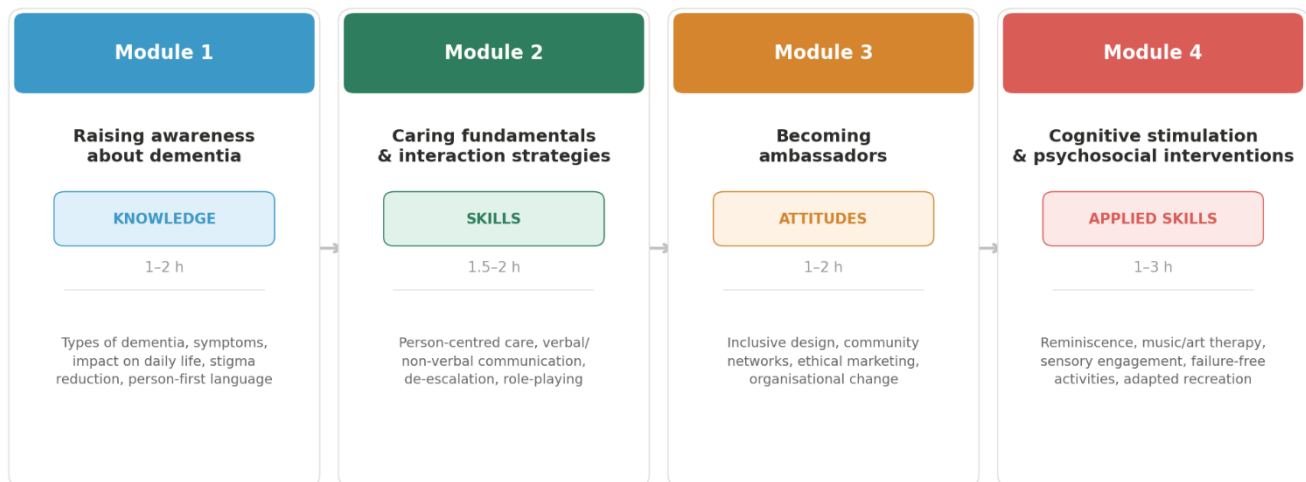
Regardless of geography, the Action Plan responds to a clear hierarchy of unmet needs identified through WP1. For the guest, the primary need is identity: to maintain the role of "traveller" and not be reduced to a diagnosis. For the caregiver, the need is relational security: the certainty of arriving at a destination where the burden of care is shared with competent staff. For the operator, the need is technical competence: replacing the stress of "not knowing what to do" with mastery of effective relational protocols.

**Hierarchy of unmet needs across the cross-border area**  
Three stakeholders, three distinct needs — identified through the WP1 territorial analysis (D1.2.1)



### 3. Training methodology and pilot validation

#### 3.1 The four-module curriculum (D2.3.1)



The ADRINCLUSIVE capacity-building programme follows an experiential learning model structured in four modules, each addressing a distinct dimension of professional competence:

**Module 1 — Raising awareness about dementia (knowledge).** The training begins with a demystification of the condition. The objective is to provide operators with a common scientific language, clearly distinguishing between physiological ageing and cognitive decline. Understanding "the person behind the diagnosis" is the first step to dismantling stigma.

**Module 2 — Caring fundamentals and interaction strategies (skills).** This is the operational core of the training, applying person-centred care principles and equipping participants with non-verbal communication techniques, emotional validation, de-escalation strategies, and practical responses to common challenging situations (disorientation at check-in, agitation in dining areas, wandering in public spaces). Role-playing and simulations allow operators to practise in a safe environment.

**Module 3 — Becoming ambassadors (attitudes/organisation).** The training moves from individual competence to collective responsibility, asking participants to become promoters of the dementia-friendly model within their organisations. This includes principles of inclusive design, local community networks, ethical and inclusive marketing, and the strategic value of a tourism offer that responds to a real and growing social need.

**Module 4 — Cognitive stimulation and psychosocial interventions (applied skills).** The final module integrates non-pharmacological approaches into the recreational offer: reminiscence therapy, sensory stimulation, music and art therapy, the Hobart dance method. The objective is to transform holiday time into a sequence of "meaningful experiences" that the guest and caregiver can live and remember positively.

Italy – Croatia

**ADRINCLUSIVE**

3.2 Pilot delivery and validation (D2.4.1)

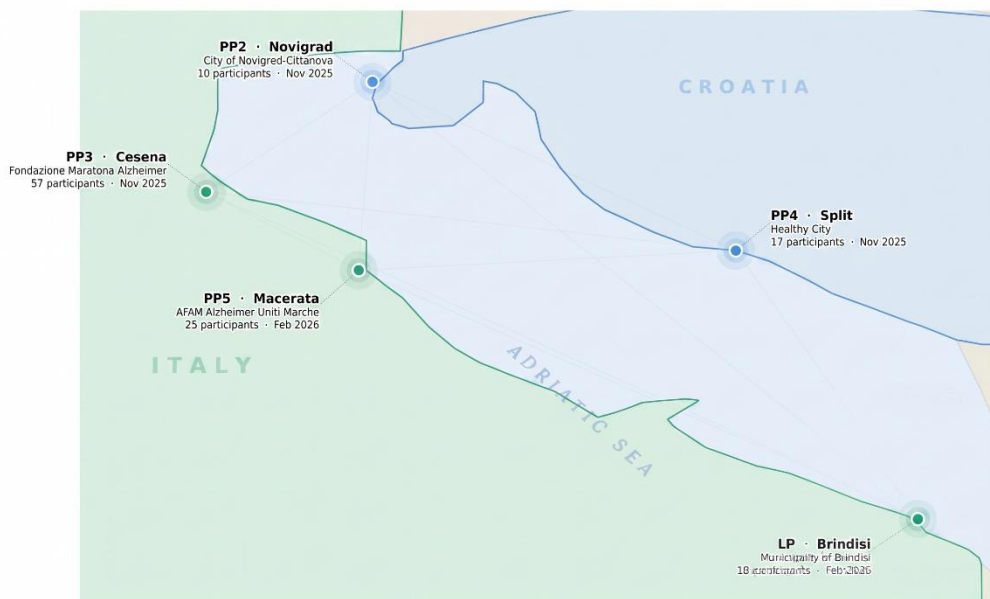
The methodology was validated through five pilot training programmes delivered between November 2025 and February 2026, covering the full Italy-Croatia cross-border area.

Partner	Country	Location	Dates	Hours	Participants	Tourism	Welfare
Municipality of Brindisi (LP)	Italy	Brindisi	18 & 23 Feb 2026	6	18	4	14
City of Novigrad-Cittanova (PP2)	Croatia	Novigrad	05 Nov 2025	6	10	8	2
Fondazione Maratona Alzheimer (PP3)	Italy	Cesena / Forlimpopoli	04, 11 & 13 Nov 2025	11	57	9	4 (+44 students)
Healthy City (PP4)	Croatia	Split	26 & 27 Nov 2025	6	17	12	5
AFAM Alzheimer Uniti Marche (PP5)	Italy	Macerata	04 & 10 Feb 2026	9	25	5	20
<b>Total</b>		<b>5 locations, 2 countries</b>		<b>38</b>	<b>127</b>	<b>38</b>	<b>45 (+44 students)</b>

The pilots tested the methodology across a deliberately diverse range of conditions: single-day

**ADRINCLUSIVE pilot training locations**

Cross-border area, Italy-Croatia · November 2025 – February 2026



intensives (Novigrad) and multi-day formats (Brindisi, Split, Macerata); small groups of 10 (Novigrad) and large mixed cohorts of 57 (Cesena/Forlimpopoli); predominantly tourism-oriented groups (Novigrad, Split) and predominantly welfare-oriented groups (Brindisi, Macerata); active professionals and hospitality school students (Cesena, Split). This diversity was not incidental but built into the plan: it ensured that

the methodology was tested under conditions representative of the full range of operational contexts it will encounter in future replication.

## 4. Impact and results

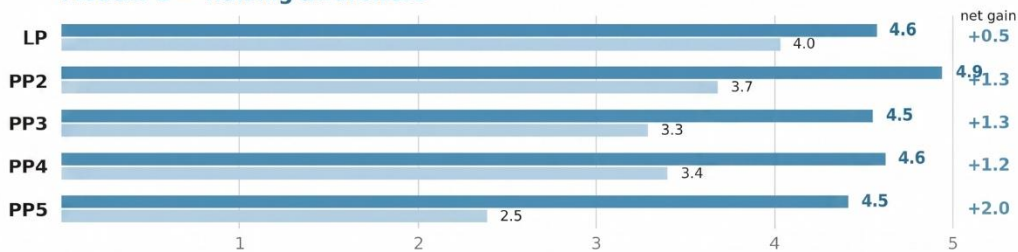
### 4.1 Quantitative evidence

All pilots adopted the pre- and post-assessment protocol prescribed by the methodology, using Likert-scale questionnaires (1–5) administered before and after the training for each module. Results demonstrate consistent and substantial improvements across all territories and all modules.

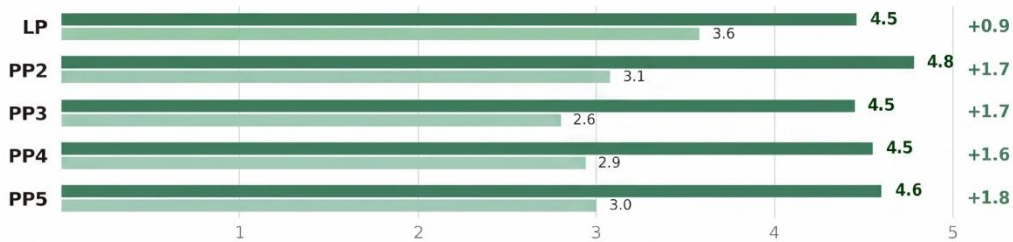
#### Training impact: pre/post assessment scores across all pilots

Likert scale 1-5 · Light = pre-training · Dark = post-training · 127 participants across 5 locations

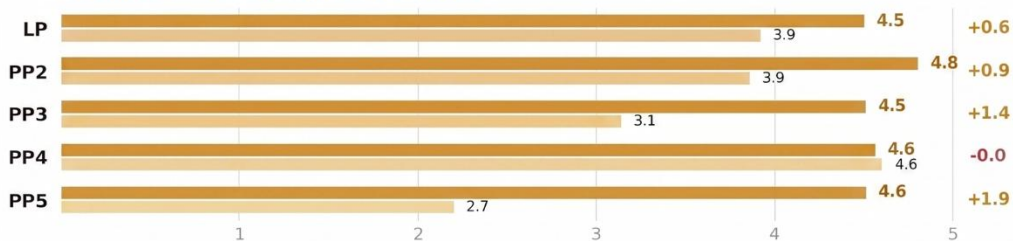
##### Module 1 – Raising awareness



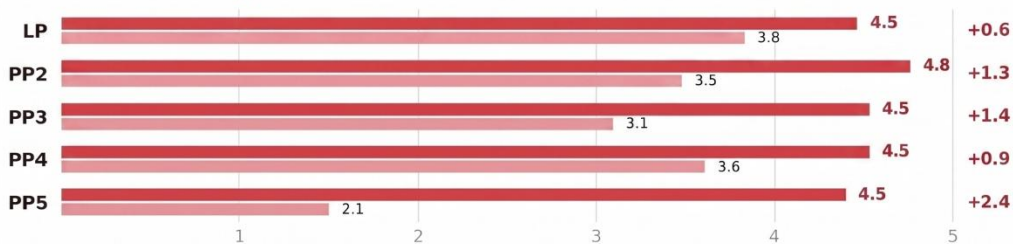
##### Module 2 – Interaction strategies



##### Module 3 – Becoming ambassadors



##### Module 4 – Cognitive stimulation



## Italy – Croatia



Module	LP (Brindisi)	PP2 (Novigrad)	PP3 (Cesena)	PP4 (Split)	PP5 (Macerata)
<b>M1 — Awareness</b>	4.03 → 4.57	3.68 → 4.94	3.29 → 4.55	3.40 → 4.62	2.00 → 4.30
<b>M2 — Interaction</b>	3.58 → 4.46	3.08 → 4.78	2.80 → 4.45	2.94 → 4.55	2.40 → 4.60
<b>M3 — Ambassadors</b>	3.92 → 4.50	3.86 → 4.80	3.14 → 4.51	4.60 → 4.56	2.20 → 4.40
<b>M4 — Cog. stimulation</b>	3.83 → 4.46	3.48 → 4.76	3.09 → 4.53	3.61 → 4.53	1.50 → 4.40

The single most significant finding is the consistent pattern across all pilots: Module 2 (Caring Fundamentals and Interaction Strategies) registered the largest net gain in every territory where the pre-assessment baseline was below 4.0. In the FMA pilot — the largest and most analytically rigorous — the net gain for Module 2 was +1.65 points, closing the widest initial competence gap (from 2.80 to 4.45). This confirms that the practical, skills-based content based on role-playing and simulation exercises is the most effective component for bridging the operational anxiety identified in the needs assessment.

The Macerata pilot (AFAM) recorded the lowest pre-assessment baselines of all five pilots (Module 4 pre-score: 1.50) and consequently the largest absolute gains, with Module 4 registering a +2.90 increase — the single largest module-level gain across the entire programme. This reflects both the genuine starting unfamiliarity of the welfare-heavy participant group with cognitive stimulation techniques and the effectiveness of the extended 3-hour hands-on workshop format adopted for that module.

#### 4.2 Qualitative impact

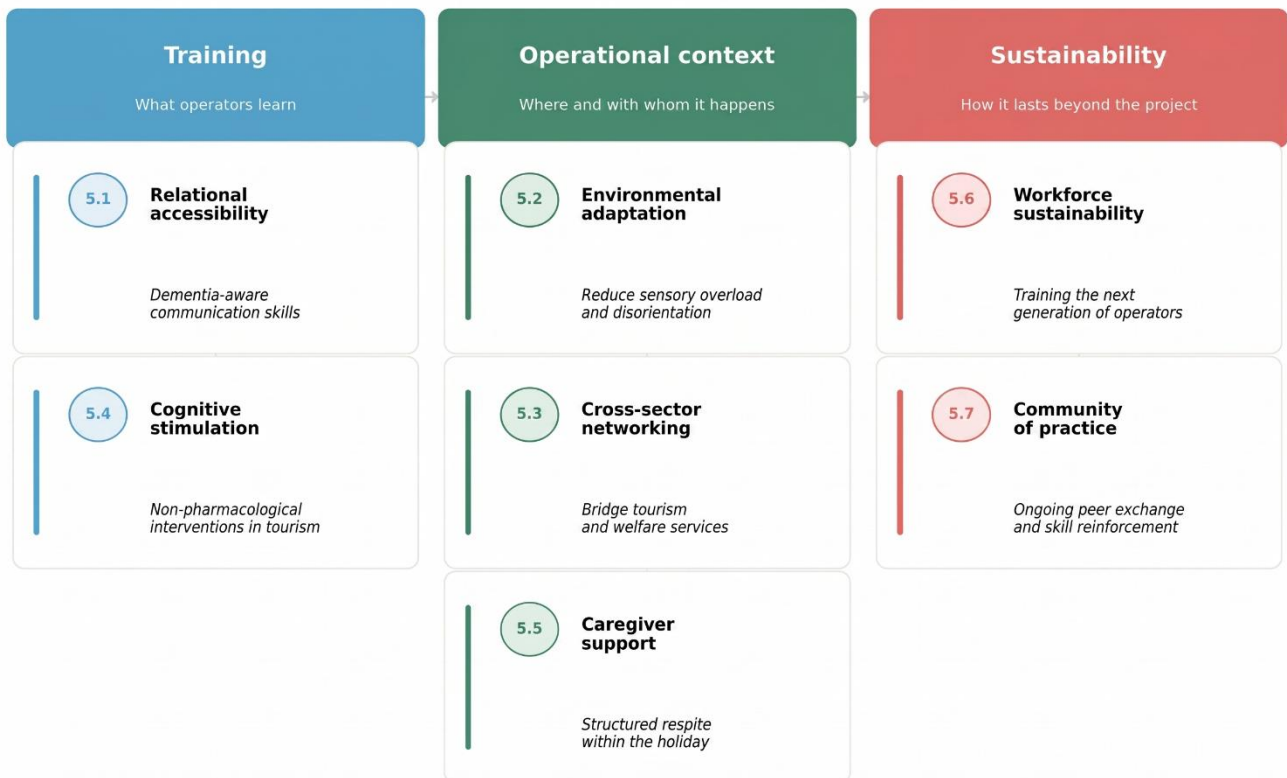
Beyond the numerical evidence, the partner reports reveal a consistent qualitative transformation in participant attitudes. A recurring finding across all five pilots was the phenomenon of "hidden experience": many operators had already encountered guests with dementia in their daily work but had always acted on pure intuition, often with a sense of inadequacy. The training provided them with a formal methodological framework that transformed this intuitive practice into a conscious and confident professionalism. This new confidence fed a strong "intention to act," with managers and frontline staff expressing a concrete desire to modify their physical spaces and reception protocols to better respond to the needs identified during the training.

An equally important impact was observed in the involvement of students. FMA's dual-track pilot in Cesena and Forlimpopoli, which included 44 hospitality school students alongside 13 active professionals, demonstrated that the methodology — designed for adult professionals — can also effectively engage adolescent audiences. The students' natural sensitivity and speed in absorbing person-centred care values indicate that the project touched a fundamental chord for the future of the sector. These young operators demonstrated that empathy and acceptance of individual dignity beyond pathology can become professional standards from the very start of a career.

Every pilot flagged the same limitation: time. Six hours — the minimum set by the methodology — was universally perceived as insufficient, with near-universal requests for more practical exercises, deeper topic exploration, and follow-up sessions. This feedback validates the methodology's own recommendation that six hours should be treated as a floor, not a ceiling, and informs the action framework below.

## 5. Action framework for replication

The following framework translates the validated methodology and pilot findings into concrete, replicable actions across seven intervention areas. Each action is linked to its source in the ADRINCLUSIVE evidence base and specifies the responsible actors, tools, and success indicators.



### 5.1 Relational accessibility — closing the knowledge and interaction gap

**Objective:** Replace operational anxiety with structured competence in dementia-aware communication.

**Actions:**

- Deliver Module 1 (awareness) and Module 2 (interaction strategies) as a minimum mandatory package for all tourism frontline staff, using the D2.3.1 methodology and pre/post assessment tools.
- Integrate role-playing scenarios tailored to local hospitality contexts (hotel reception, restaurant service, guided tours, transport) into every delivery, drawing on the scenario bank validated across the five pilots.
- Provide operators with communication scripts and visual reference cards for the most common challenging situations (disorientation at check-in, agitation in shared spaces, repetitive questions, wandering).

**Tools:** D2.3.1 training methodology, D2.4.1 pilot report templates, pre/post Likert questionnaires, communication script bank.

**Indicator:** Post-training average score of 4.0 or above on Module 2 assessment across all participant groups.

## 5.2 Environmental adaptation — reducing cognitive overload

**Objective:** Reduce disorientation and sensory overload in hospitality environments through targeted, low-cost interventions.

**Actions:**

- Conduct an environmental audit of participating tourism facilities using the environmental checklist derived from D2.3.1, identifying sensory "traps" (complex floor patterns, poor lighting, excessive noise, lack of visual orientation cues).
- Install high-contrast signage (yellow on black or white on dark blue) at eye level in corridors, bathrooms, dining areas, and common spaces.
- Designate and equip at least one "quiet space" per facility — a decompression zone with soft lighting, minimal stimulation, and comfortable seating where guests can regain orientation.
- Redesign check-in and service processes to reduce cognitive load: seated check-in, visual menus with icons and photographs, simplified room orientation cards.

**Tools:** Environmental audit checklist (D2.3.1), signage templates, visual menu templates, quiet space design guidelines.

**Indicator:** Completion of environmental audit and implementation of at least 3 adaptations per participating facility.

### 5.3 Cross-sector networking — bridging tourism and welfare

**Objective:** Establish operational links between tourism operators and local welfare/health services in each pilot territory.

**Actions:**

- In each territory, formalise a local network protocol linking at least one tourism operator, one health/social care provider, and one dementia care association, defining roles, communication channels, and escalation procedures for the management of guests with dementia.
- Organise at least one joint cross-sector workshop per territory, bringing tourism and welfare professionals together in the same room — replicating the cross-sector participant mix that proved effective in all five pilots.
- Create a shared contact list and rapid-response protocol for situations requiring clinical support during tourist stays.

**Tools:** Network protocol template, joint workshop facilitation guide, rapid-response contact framework.

**Indicator:** Formal network protocol signed in at least 3 territories.

#### 5.4 Cognitive stimulation in the tourism offer — meaningful experiences

**Objective:** Integrate non-pharmacological interventions into the recreational and hospitality offer.

**Actions:**

- Train a minimum of 2 operators per facility in Module 4 techniques (reminiscence, sensory stimulation, adapted recreational activities, the Hobart dance method) using the extended workshop format validated in the Macerata pilot (3 hours minimum for this module).
- Develop a "meaningful activities menu" for each participating territory, identifying local cultural, natural, and recreational resources that can be adapted for guests with dementia (guided walks, museum visits, music evenings, local history corners, sensory gardens).
- Design "failure-free activities" — structured group experiences that are enjoyable regardless of cognitive ability and can be offered as part of the standard entertainment programme without segregating guests with dementia.

**Tools:** Module 4 activity bank (D2.3.1), meaningful activities menu template, failure-free activity design guidelines.

**Indicator:** At least 3 adapted activities integrated into the tourism offer per pilot territory.

### 5.5 Caregiver support — respite within the holiday

**Objective:** Ensure that the inclusive tourism offer includes structured respite for caregivers.

**Actions:**

- Within the holiday programme, dedicate specific time slots where trained staff take over engagement with the guest while the caregiver has dedicated personal time.
- Provide caregivers with a pre-arrival information pack describing the facility's dementia-friendly features, available support, emergency contacts, and daily programme, reducing the "fear of the unknown" identified as a key barrier in D1.2.1.
- Offer a post-stay feedback channel to capture caregiver perspectives on the experience and feed continuous improvement.

**Tools:** Caregiver information pack template, respite scheduling guide, post-stay feedback questionnaire.

**Indicator:** Caregiver satisfaction score of 4.0 or above on post-stay evaluation.

### 5.6 Workforce sustainability — training the next generation

**Objective:** Embed dementia-aware hospitality training in the educational pathways of future tourism professionals.

**Actions:**

- Building on the successful student engagement in the FMA pilot (44 students at the Artusi hospitality school) and the Split pilot (4 hospitality school students), develop a standardised 5-hour curricular module adapted from the ADRINCLUSIVE methodology for integration into hospitality school programmes.
- Establish partnerships with at least 2 hospitality training institutions (one in Italy, one in Croatia) to pilot the curricular integration during the 2026–2027 academic year.
- Engage university-level partners — as demonstrated in the Macerata pilot, where 3 university professors participated — to explore integration of inclusive tourism content into higher education programmes in tourism management and social care.

**Tools:** Curricular adaptation guide, student-adapted D2.3.1 materials, partnership agreement template.

**Indicator:** Curricular module piloted in at least 2 educational institutions.

### 5.7 Continuity and community of practice

**Objective:** Prevent knowledge decay after initial training by establishing ongoing support structures.

**Actions:**

- Organise follow-up refresher workshops (2–3 hours) at 6-month intervals after initial training, focusing on practical skill reinforcement and sharing of real-world experiences.
- Establish a cross-border digital community of practice connecting trained operators across all pilot territories, enabling peer-to-peer exchange, case discussion, and sharing of adapted resources.
- Document and disseminate case studies from the pilot inclusive tourism activities (WP3) to provide concrete evidence of the training's practical application.

**Tools:** Refresher workshop facilitation guide, digital community platform, case study template.

**Indicator:** At least 60% of trained operators participating in at least one follow-up activity within 12 months.

## 6. Challenges and forward outlook

### 6.1 Strengths confirmed by the pilots

The five pilots confirmed three central strengths of the ADRINCLUSIVE approach.

First, **its immediate applicability**: participants consistently reported that the training content was directly relevant to their daily work, with many noting that it formalised intuitive practices they had already been applying without confidence.

Second, the **effectiveness of experiential methods**: role-playing, simulations, and hands-on cognitive stimulation exercises consistently outperformed lecture-based content in both engagement and measured learning gains.

Third, the **transferability of the model across different territorial contexts**: the methodology proved equally effective in small Croatian municipalities (Novigrad, 10 participants) and larger Italian academic settings (Macerata, 25 participants), with predominantly tourism groups and predominantly welfare groups, with active professionals and students.

### 6.2 Challenges to address

The pilots also revealed four challenges that must inform future implementation:

- 1. Time optimisation.** Coordinating 6-hour training sessions with the working schedules of tourism and welfare operators was the most cited logistical difficulty, particularly in Novigrad where both sectors had to align on a single day. Future implementations should adopt more flexible, modular formats — shorter sessions spread over multiple days, blended online/in-person delivery (Modules 1 and 3 can be delivered remotely, as noted in the methodology), and evening or low-season scheduling to minimise operational impact.
- 2. Demand for clinical depth.** Several pilots reported explicit requests from participants for more detailed medical content on dementia. This indicates that the tourism sector is ready to move beyond simple "awareness-raising" into a phase of technical specialisation. Future versions of the training should consider an optional advanced module on clinical aspects, delivered in partnership with local health services.
- 3. Cross-sector recruitment asymmetry.** The two-sector recruitment challenge was real in every pilot: partners rooted in health/social care networks found it harder to attract tourism operators, and vice versa. Brindisi and Macerata leaned heavily welfare (78–80% of participants), while Novigrad and Split drew predominantly from tourism (70–80%). Future implementations should plan recruitment strategies that actively target the underrepresented sector in each territory.
- 4. Academic sustainability.** The most ambitious challenge is the integration of the ADRINCLUSIVE training package into formal educational curricula. The successful engagement of hospitality school students in Cesena/Forlimpopoli and Split demonstrates the demand and feasibility, but translating a project-based training into a permanent curricular element requires institutional partnerships and policy engagement that extend beyond the project timeline.