SAFE HANDS SUPPORT

Physical Therapy Guide

A comprehensive resource for movement, strength, pain management, recovery, and everyday independence

Prepared for Safe Hands Support as an original educational resource. This guide is designed to support clients, families, carers, and staff with practical, easy-to-understand information about physical therapy. It does not replace an individual assessment or treatment plan from a qualified health professional.

Version 1.0 | March 2026

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1. Understanding physical therapy

Physical therapy, often called physiotherapy in Australia, is a health profession focused on movement, function, recovery, and participation in everyday life. A physical therapist examines how a person moves, what limits them, what causes pain or reduced performance, and what can be improved through a structured plan. The aim is not only to treat a sore body part, but to help the person move better, do more, and stay as independent as possible.

Authoritative professional organisations describe physical therapy as a service that helps improve movement, manage pain, restore function, and prevent disability. In practice, this means physical therapy can support someone after surgery, after a sports injury, during recovery from illness, when balance becomes poor, when chronic pain makes daily life harder, or when weakness and stiffness slowly reduce independence. It is used across hospitals, community settings, rehabilitation services, aged care, private clinics, sporting environments, and home-based support.

At Safe Hands Support, physical therapy information is especially useful because movement affects nearly every part of daily living. Walking to the bathroom, getting out of bed, climbing a step, lifting groceries, reaching overhead, standing safely in the shower, turning in bed, or getting into a car all depend on strength, joint range, coordination, confidence, and pain control. When one of these areas changes, the effect is often much bigger than just discomfort. It can change a person’s routine, social life, sleep, work, exercise habits, and self-confidence.

A good physical therapy plan usually combines assessment, education, exercise, and practical problem solving. Some sessions may include hands-on treatment, but the long-term goal is usually self-management. In other words, therapy works best when the person understands their condition, knows what they are trying to improve, practises the right exercises, and builds safe habits over time. Physical therapy is therefore both a treatment service and a teaching process.

It is also important to understand what physical therapy is not. It is not a one-time quick fix. It is not simply massage. It is not about pushing through severe pain. It is not the same for everyone with the same diagnosis. Two people can both have knee pain, for example, but one may mainly need strength work, one may need balance retraining, and another may need advice about pacing activity and reducing fear of movement. Individual assessment matters.

Another important idea is function. Function means real activities that matter to the person. Someone may not care whether their shoulder can move to a textbook angle, but they do care whether they can wash their hair, carry their child, sleep without pain, or return to work. Physical therapy is strongest when treatment is linked to meaningful goals. This makes progress clearer and improves motivation.

Physical therapy is relevant across the full lifespan. Children may need support for developmental, neurological, or musculoskeletal needs. Adults may seek help after injury, surgery, pregnancy-related changes, work strain, or sport. Older adults often need therapy for mobility decline, falls prevention, balance, frailty, pain, arthritis, or recovery after hospitalisation. The overall principles stay similar, but the exact program is matched to age, health status, environment, and goals.

For Safe Hands Support, the biggest practical message is simple: better movement often leads to better life participation. When pain reduces, when balance improves, when strength returns, and when the person understands how to manage their body safely, their world usually becomes bigger again.

Table 1. What physical therapy is designed to improve

Area	What improvement may look like in daily life
Movement	Walking more smoothly, turning with less hesitation, reaching more comfortably, transferring more safely.
Pain management	Less interference from pain during sleep, self-care, community access, and exercise.
Strength	Easier stair climbing, chair rises, carrying, and balance recovery.
Flexibility	Better bending, reaching, dressing, and movement confidence.
Independence	Needing less physical help or supervision for everyday tasks.

Key messages for clients and families

- Physical therapy is about function, not just body parts.
- The plan should match the person's own goals and daily life.
- Active participation usually matters more than passive treatment alone.
- Education and routine are as important as the appointment itself.

2. Why people use physical therapy

People seek physical therapy for many reasons, but most reasons fall into a few broad groups: pain, weakness, stiffness, poor balance, reduced endurance, limited mobility, recovery after injury or surgery, difficulty with daily tasks, and the need to maintain independence. Some people come early, when a problem first starts. Others come much later, after weeks, months, or even years of adapting around a problem that keeps getting worse.

One of the most common reasons is pain. This may be pain from a sudden injury, such as an ankle sprain or muscle strain, or pain from a longer-term issue such as osteoarthritis, neck pain, back pain, tendon irritation, or persistent pain after surgery. A physical therapist does not only ask where the pain is. They also look at how the person moves, what activities aggravate symptoms, what positions help, how strong the area is, whether flexibility is limited, whether swelling is present, and how much the pain has changed the person's routine.

Weakness is another major reason. Weakness may develop after a period of bed rest, after an operation, after a fracture, after a neurological event, or simply after a long time of moving less because of pain. Weakness often causes secondary problems. A weak hip may increase knee strain. Weak trunk muscles may reduce postural support. Weak ankle muscles may increase fall risk. This is why physical therapy usually looks at the movement chain rather than only one small area.

Flexibility and range of motion problems are also common. A person may find it hard to bend, straighten, rotate, kneel, reach, or turn. Sometimes this happens because soft tissues are tight. Sometimes it is due to joint stiffness, swelling, scar tissue, pain-related guarding, or fear of movement. Limited range can affect comfort, but more importantly it can affect function. Not being able to fully straighten a knee changes walking. Not being able to lift the shoulder changes dressing and grooming.

Balance and coordination problems are especially important for older adults and people with neurological or vestibular conditions. Poor balance can make a person slower, less confident, and more dependent on others. It may also lead to falls, which can have serious physical and emotional effects. A person who falls once may begin avoiding walking outside, showering alone, stairs, or community activities. Physical therapy can help by improving strength, reaction time, postural control, stepping strategy, confidence, and environmental awareness.

Physical therapy is also widely used after surgery. Common examples include joint replacement, ligament repair, spinal surgery, fracture fixation, and many soft tissue procedures. The goals may include reducing swelling, restoring movement, improving gait, rebuilding strength, protecting healing tissues, and gradually returning to normal tasks. The therapist also helps translate medical restrictions into everyday action, such as how to get in and out of bed, how to use a walking aid, or when to begin more demanding exercise.

Injury recovery is another major area. Sports injuries, workplace injuries, motor vehicle injuries, and day-to-day sprains and strains can all benefit from a staged rehabilitation plan. Without rehabilitation, the pain may settle but the body may still be weak, stiff, or poorly controlled, which can increase the chance of re-injury. Therapy fills the gap between being injured and truly being ready for full function again.

Some people use physical therapy for chronic conditions rather than a single event. Arthritis, osteoporosis, neurological conditions, cardiopulmonary limitations, chronic low back pain, fibromyalgia, hypermobility, and deconditioning can all reduce function over time. In these cases, therapy often focuses on management rather than cure. The aim is to improve capacity, reduce flare-ups, protect confidence, and keep the person active for as long as possible.

There is also an important preventative side. People do not have to wait for a major problem. Therapy can identify movement habits, strength gaps, fall risks, ergonomic issues, and training errors before they become larger problems. Prevention is often less dramatic than rehabilitation, but it is just as valuable.

For a support service like Safe Hands Support, this chapter matters because it shows how wide the role of physical therapy can be. The need is not limited to people with major injuries. It can help anyone whose movement, comfort, safety, or independence is being reduced by a physical issue.

Table 2. Common reasons people are referred to physical therapy

Presentation	Typical impact on life	Therapy focus
Pain	Reduced sleep, activity avoidance, low confidence	Education, pacing, movement, strength, and symptom management
Weakness	Harder transfers, stairs, carrying, balance loss	Progressive strengthening and functional task practice
Stiffness	Difficulty dressing, bending, turning, walking	Mobility work, stretching, and graded use
Falls risk	Fear of movement, reduced independence	Balance training, strengthening, environmental review
Post-surgery recovery	Swelling, limited range, slow gait	Protection, movement restoration, strength, function

3. How assessment and goal setting work

The first stage of physical therapy is assessment. A good assessment is not rushed guessing. It is a structured process that combines listening, observation, movement testing, clinical reasoning, and goal setting. The therapist gathers information to understand both the person and the problem.

Assessment often begins with the history. The therapist may ask what the main issue is, when it started, how it behaves, what makes it better or worse, what the person can and cannot do, whether there has been previous treatment, what medications are being used, whether there are scans or medical reports, and whether there are any red flags that need medical review. This conversation is important because it shapes the rest of the session.

The next stage is usually observation and movement analysis. The therapist may watch how the person sits, stands, walks, bends, transfers, reaches, climbs steps, or completes a task that normally causes difficulty. Sometimes the most useful information comes from watching a real movement rather than from a static test on a treatment bed. A person may look fine lying down, but struggle during a sit-to-stand, a squat, a turn, or a single-leg step.

Physical testing may include range of motion, strength testing, flexibility assessment, balance tests, coordination checks, sensation review, swelling measurement, gait analysis, and condition-specific measures. For some people, standardised outcome measures are used. These may assess pain severity, walking speed, fall risk, endurance, disability, confidence, or function. Good therapists often retest key measures later so progress can be shown clearly rather than guessed.

Assessment also includes the person’s context. A program has to match the real world. It matters whether the person lives alone, has stairs at home, uses a walking aid, works in a physically demanding role, has a history of falls, feels anxious about movement, has support from family, or struggles to remember exercises. This is why good therapy plans are personalised. The body does not live separately from the person’s daily life.

Goal setting is one of the most important parts of therapy. A general goal like “get better” is too vague. Better goals are specific and functional. Examples include walking to the local shops without stopping, getting up from the floor safely, standing to cook for 20 minutes, improving shoulder movement enough to dress independently, returning to gym training, or reducing near-falls in the bathroom. Goals should matter to the client, not just to the therapist.

A useful way to think about goals is short term, medium term, and long term. A short-term goal may be reducing swelling and improving confidence with transfers. A medium-term goal may be walking independently indoors. A long-term goal may be returning to full work duties or community sport. This staged approach helps people stay motivated because they can see progress in smaller steps.

Therapists also educate clients about the likely pathway. Tissue healing, strength gains, balance improvements, and habit change all take time. A therapist should explain what is expected in the first week, first month, and later phases. This helps reduce frustration. People often stop too early because they think progress should be immediate. Clear expectations support adherence.

Reassessment is just as important as the first assessment. Good therapy is responsive. If the person is improving, the plan should progress. If they are not improving, the therapist may need to change exercises, investigate another driver, reduce load, review technique, or communicate with the broader healthcare team. Progress is rarely perfectly straight. Some days are better than others. The role of reassessment is to stay guided by evidence, not by assumption.

At Safe Hands Support, goals should also connect with support routines. If a person's therapy goal is to walk safely from bedroom to bathroom at night, support staff need to understand what assistance level is appropriate, what cues help, what equipment is needed, and what signs show fatigue or risk. Therapy works best when everyone supporting the person understands the same plan.

Questions often asked during assessment

- What is your main problem right now?
- When did it start and how has it changed?
- What activities are difficult or avoided?
- What would you most like to get back to doing?
- What support, equipment, or barriers do you have at home?

Table 3. Turning broad aims into useful goals

Broad aim	Better functional goal
Get stronger	Stand from the couch independently 10 times with good control.
Walk better	Walk to the local mailbox and back without needing to stop.
Use my shoulder normally	Reach overhead to wash and dry hair without assistance.
Stop falling	Turn safely in the bathroom and walk to bed at night without near-falls.

4. Core treatment methods

Physical therapy uses a range of treatment methods. The exact mix depends on the condition, the stage of recovery, and the person's goals. Although treatments vary, most high-quality therapy programs combine movement-based treatment with education and practical strategies.

One of the main methods is therapeutic exercise. This is not random exercise. It is planned exercise chosen for a purpose. It may aim to improve strength, flexibility, endurance, balance, control, coordination, breathing, walking, or tolerance for daily tasks. Exercises are often changed over time. Early-stage exercises may be simple and gentle. Later-stage exercises may be more demanding and more functional, such as step training, reaching tasks, resistance training, or return-to-sport drills.

Manual therapy refers to hands-on treatment by the therapist. This can include joint mobilisation, soft tissue techniques, stretching assistance, or movement guidance. Manual therapy may help reduce stiffness, improve comfort, or make movement easier in the short term. However, it usually works best when combined with active exercise. Passive treatment alone often does not create lasting change unless the person also builds movement capacity.

Functional training is another major method. This means practising meaningful tasks rather than only isolated exercises. For example, instead of only strengthening the thigh muscles on a bed, therapy may include repeated sit-to-stands, step-ups, reaching, stair practice, walking around obstacles, bed mobility, transfers, or carrying light loads. Functional practice helps the gains transfer into real life.

Education is a treatment in itself. A person who understands their condition usually manages it better. Education may include advice about posture, pacing, load management, safe lifting, walking strategies, warm-up and cool-down, flare-up management, joint protection, sleep positioning, use of ice or heat, and the difference between acceptable exercise discomfort and warning-sign pain. Education helps reduce fear and improves independence.

Balance and gait retraining are common, especially in older adults or people recovering from neurological or orthopaedic issues. These programs may include changing base of support, turning, stepping in different directions, dual-task practice, reaction training, strengthening the trunk and legs, safe challenge to the balance system, and walking practice with or without aids.

Cardiorespiratory and endurance training may be included when general conditioning has declined. A person recovering from illness, surgery, or prolonged inactivity may fatigue quickly even if one painful body part is improving. Building walking endurance, step tolerance, cycling time, or low-impact aerobic capacity can greatly improve participation in daily life.

Physical agents or modalities may sometimes be used. These can include heat, cold, compression, electrical stimulation, or ultrasound. Their role varies depending on the condition. They may help with symptom relief, especially early in rehabilitation, but they are usually not the main driver of long-term functional recovery. Current guideline-based care for some chronic pain conditions places more emphasis on exercise, education, and active management than on repeated passive modalities.

Taping, bracing, and supportive devices may also form part of treatment. These are not always needed, but they can be helpful in certain cases for symptom relief, temporary support, swelling

control, or confidence while an area regains capacity. The key word is temporary. The long-term aim is usually safe, independent movement, not permanent dependence on external support unless clinically required.

Breathing and relaxation strategies may be added, especially when pain, fear, guarding, or fatigue are prominent. Persistent pain often affects more than tissue. It changes stress levels, sleep, movement confidence, and muscle tension. For some people, learning to slow breathing, relax unnecessary tension, and pace activity is a major part of progress.

The best treatment method is not the fanciest one. It is the one that is safe, evidence-based, goal-directed, realistic, and consistent with the person's needs. At Safe Hands Support, this principle matters because support workers and carers often see the daily carryover. The strongest therapy plan is the one the person can keep doing.

Table 4. Main treatment methods and their purpose

Method	Main purpose	Important note
Therapeutic exercise	Build capacity and function	Usually the backbone of long-term improvement
Manual therapy	Short-term symptom or mobility assistance	Often works best when paired with active rehab
Functional training	Improve real-life task performance	Transfers gains into daily activities
Education	Improve understanding and self-management	Essential for adherence and confidence
Modalities	May reduce symptoms in some cases	Usually supportive rather than the main long-term solution

5. Pain, inflammation, and tissue healing

Pain is one of the main reasons people seek physical therapy, yet pain is often misunderstood. Pain is a protective signal, but it is not a perfect measure of tissue damage. In early injury, pain often reflects inflammation and tissue irritation. In longer-term problems, pain can also be influenced by reduced strength, stiffness, fear of movement, poor sleep, stress, sensitivity of the nervous system, or repeated flare-ups.

Inflammation is part of normal healing. In the early phase after injury or surgery, the body sends blood flow and healing cells to the area. This can create warmth, swelling, tenderness, and reduced movement. During this stage, the aim is usually to protect the tissue without becoming completely inactive. Too much stress too early can irritate healing tissue. Too little movement for too long can create stiffness, weakness, and delayed function. Physical therapy helps find the right middle ground.

Tissue healing usually happens in phases. The exact timeline depends on the tissue and the person. Muscle strains may recover faster than tendon problems. Bone healing follows different timelines from ligament healing. Surgery also changes timelines depending on what was repaired or reconstructed. A good therapist explains that recovery is not only about pain settling. It is also about restoring strength, control, tolerance, and confidence.

Acute pain and persistent pain are not the same. Acute pain is usually linked closely to a recent injury or irritation. Persistent pain can continue even after tissue healing time has passed. This does not mean the pain is imaginary. It means the pain system has become more sensitive or complex. In persistent pain, movement may still be safe and helpful, but it often needs to be introduced gradually and with good education to avoid boom-and-bust cycles.

A common therapy principle is graded exposure or graded activity. This means building up movement in planned amounts rather than waiting until the body feels perfect. For example, if walking five minutes is comfortable but ten minutes causes a flare, the program might start with five to six minutes done consistently, then build slowly. This approach is often more successful than alternating between overdoing activity on good days and resting too much on bad days.

Pain during exercise needs context. Not all discomfort means harm. In some conditions, mild and temporary symptom increase during rehabilitation can be acceptable if it settles quickly and the person is not worsening overall. However, severe pain, sharp instability, marked swelling, loss of function, or pain that keeps escalating after exercise can signal that the load is too high or that reassessment is needed. Clients need clear guidance on this difference.

Swelling management may include elevation, compression when appropriate, movement within safe limits, circulation exercises, and gradual loading. Heat may help stiffness in some cases, while cold may help early pain and swelling for some people. These are symptom tools, not full solutions. The most important part of recovery is usually progressive return to movement.

Sleep, stress, and confidence matter too. Poor sleep increases pain sensitivity. High stress can increase guarding and fatigue. Fear of movement can lead to avoidance, which causes deconditioning and reinforces the idea that the body is fragile. Education and guided movement help reverse this pattern. People usually do better when they understand that safe, gradual movement is part of recovery rather than something separate from it.

At Safe Hands Support, carers and staff can play a major role in pain management by helping the person pace activity, maintain gentle routine, notice patterns, support safe exercise adherence, and avoid unhelpful all-or-nothing behaviour. Pain care works best when the whole environment supports calm, consistent, sensible movement.

A simple way to explain healing

Early recovery is often about calming irritation and protecting the area. The next stage is about restoring movement. Later stages focus on rebuilding strength, endurance, and confidence. Pain can reduce before function is fully restored, which is why stopping rehabilitation too early can be a mistake.

Table 5. Responding to symptom changes

Response	Usually reasonable action
Mild muscle soreness after new exercise	Monitor, continue with sensible load, and allow recovery.
Short-term stiffness next morning	Use gentle movement and reassess whether the program was a new challenge.
Major swelling, sharp instability, or severe worsening	Pause and seek clinician or medical review.
Boom-and-bust fatigue pattern	Reduce peaks, pace activity, and build a steadier routine.

6. Strength, flexibility, and endurance

Strength, flexibility, and endurance are three of the most important building blocks of function. They are linked, but they are not the same. A person can be flexible but weak. They can be strong but have poor endurance. They can have good endurance but poor mobility. Physical therapy often aims to identify which of these areas is limiting function the most.

Strength means the ability of muscles to produce force. In daily life, strength is needed for standing from a chair, climbing stairs, lifting, carrying, walking uphill, controlling posture, and protecting joints during movement. Weakness often develops after injury, surgery, inactivity, pain-related avoidance, or ageing. A person may not notice gradual weakness until an activity becomes clearly harder, such as rising from low seating or maintaining balance during a quick turn.

Flexibility and range of motion refer to how far a joint and surrounding tissues can move. Flexibility matters when tasks demand bending, reaching, rotating, kneeling, squatting, or getting into tight spaces such as a car seat or shower. Tightness can come from muscle shortening, joint stiffness, swelling, scar tissue, or guarding around pain. Good therapy targets the real driver of restriction rather than assuming every stiff movement only needs more stretching.

Endurance means the ability to keep going. A person may have enough strength for one sit-to-stand but not for ten in a row. They may walk safely for one minute but fatigue after five. They may complete exercises in clinic but not have enough capacity for shopping, cleaning, or a community outing. Endurance is therefore vital for independence. It is often reduced after illness, hospital stays, long-term inactivity, pain, or chronic health conditions.

Exercise prescription should match the goal. If the goal is power for sport, the program differs from a program for safe household function after illness. If the goal is transfers and walking, strength work should focus on the trunk, hips, knees, and ankles in functional patterns. If the goal is overhead reaching, the shoulder program should also include posture, scapular control, and task-specific practice.

Progression is one of the most important ideas in exercise therapy. The body changes when it is challenged appropriately over time. If an exercise stays too easy forever, progress slows. If it is too hard too soon, the person may flare or lose confidence. Progression can involve more repetitions, more resistance, slower control, greater range, longer holds, more difficult balance positions, reduced hand support, or more complex functional tasks.

Technique also matters. A badly performed exercise can reinforce poor movement or shift stress to another area. This is why therapists often use simple cues. Examples include keeping the knee aligned during a squat, controlling the lowering phase of a step-down, breathing normally rather than holding the breath, or standing tall during walking practice. Small technique changes can improve both safety and effectiveness.

Rest and recovery are part of exercise too. Strong gains are not built by doing hard exercise every moment. Tissues need time to adapt. Some soreness can be normal after new exercise, especially when strength work begins, but symptoms should generally be manageable and should settle. A good plan balances challenge with recovery.

Physical activity guidelines also support the role of regular movement across the week. Adults are generally encouraged to include moderate to vigorous physical activity on most days, muscle-strengthening activities on two or more days per week, and functional activities for mobility, balance, and coordination on multiple days. These broad recommendations support long-term health, while therapy fine-tunes what is needed for the individual.

For Safe Hands Support, the practical lesson is that exercise is most useful when it is both targeted and realistic. The best program is not the longest list. It is the one the person can understand, tolerate, and repeat often enough to create real change.

Practical training principles

- Train the quality you actually need. Do not expect a stretching-only program to fully restore strength.
- Progress should be gradual enough to be tolerated and clear enough to matter.
- Technique protects joints and makes exercise more useful.
- Rest is part of adaptation, but long-term inactivity reduces capacity.

Table 6. Matching exercise type to a common goal

Goal	Examples
Chair and stair function	Sit-to-stands, step-ups, mini squats, heel raises
Walking endurance	Walking intervals, low-impact aerobic work, pacing plans
Reaching and self-care	Shoulder mobility, scapular control, carrying tasks
Balance recovery	Single-leg support drills, tandem work, stepping practice

7. Balance, coordination, and falls prevention

Balance is the ability to keep the body's centre of mass controlled over its base of support. In simple terms, balance is what lets a person stay upright, recover from a wobble, turn safely, step over obstacles, and move through the day without feeling unstable. Good balance depends on strength, sensation, vision, vestibular input, reaction time, attention, confidence, and safe strategy use.

Balance problems can appear in many ways. Some people sway when standing still. Some feel unsteady in the dark. Some trip when turning quickly. Some lose confidence on stairs or uneven ground. Others begin using furniture or walls for support around the home. A person may also reduce activity because they fear falling, and that reduced activity can cause even more weakness and poorer balance. This cycle is common and important to break early.

Falls prevention is a major reason for physical therapy, especially in older adults and people with reduced mobility. A fall does not only risk injury. It can lead to fear, reduced independence, social withdrawal, hospitalisation, and long-term decline in confidence. The good news is that falls are not inevitable. Exercise and targeted intervention can reduce risk.

Balance retraining may include standing with a narrower base, changing surfaces, stepping in different directions, turning practice, reaching outside the base of support, weight shifting, marching, heel-to-toe activities, sit-to-stand practice, tandem standing, dual-task drills, and walking over or around objects. Exercises are adjusted based on the person's level. The goal is challenge with safety.

Strength and balance work go together. Weak hips, weak knees, weak ankles, and weak trunk muscles all make balance less efficient. For this reason, falls-prevention programs often include lower-limb strengthening as well as direct balance drills. Walking endurance and transfer practice also matter because a person who fatigues quickly often becomes less stable later in the day.

Environmental review is another key part of falls prevention. Balance does not happen in a vacuum. Trip hazards, poor footwear, low lighting, loose mats, cluttered pathways, rushing to the toilet at night, and badly fitted walking aids can all increase risk. Therapy and support services can work together by improving both the person and the environment.

Confidence should not be overlooked. Some people are physically capable of more than they believe, while others overestimate their stability. Good therapy tries to match confidence with reality. The person should feel safe but not over-restricted. This is why supervised practice is important. When someone successfully completes gradually harder tasks, confidence becomes evidence-based rather than fear-based.

Walking aids may also be part of falls prevention, but only when correctly prescribed and correctly used. An aid that is too low, too high, badly positioned, or used inconsistently may not help. Clients often need training in how to turn, negotiate doorways, sit down, stand up, and walk on different surfaces while using the aid.

Support workers and carers are central to falls prevention. They often see the person in real situations such as the bathroom, kitchen, driveway, or community outings. They may notice

near-falls, slowing speed, reduced foot clearance, shuffling, hesitancy, or fatigue patterns before anyone else. Reporting these changes early can make a big difference.

At Safe Hands Support, a strong falls-prevention approach includes observing patterns, supporting exercise consistency, encouraging safe pacing, maintaining clear home pathways, checking footwear, and understanding when the person should be encouraged to do more independently and when they need closer supervision.

Table 7. Common falls risk contributors

Risk factor	Why it matters	Possible response
Lower-limb weakness	Less control during transfers and trips	Strength program and repeated chair rises
Poor lighting	Harder to see hazards, especially at night	Night lights and clearer pathways
Incorrect walking aid use	Reduced stability during mobility	Review fit and technique
Fear of falling	Activity avoidance and deconditioning	Supervised confidence-building practice
Clutter or loose rugs	Higher trip risk	Home setup changes

8. Recovery after injury or surgery

Recovery after injury or surgery is one of the clearest examples of why physical therapy matters. Medical treatment may repair a structure, stabilise a fracture, replace a joint, or reduce an acute problem, but rehabilitation is what helps the person regain function. Without rehabilitation, people often remain weaker, stiffer, and less confident than they need to be.

Early rehabilitation usually focuses on protection and orientation. The person needs to understand precautions, pain expectations, wound or swelling management, positioning, safe transfers, and basic mobility. They may need to learn how much weight they can put through a limb, when they should wear a brace, how to use crutches or a walker, and what symptoms are normal versus concerning.

The middle phase often focuses on restoring range, control, and foundational strength. Movement may feel awkward or guarded after injury. The person may still rely too much on the uninjured side. There may be swelling, altered walking pattern, reduced confidence, or difficulty with stairs, bed mobility, or getting in and out of chairs. Structured exercises and repeated practice are used to rebuild normal movement patterns.

Later-stage rehabilitation usually progresses toward function, endurance, and return to the person's chosen activities. This might mean household independence, work readiness, gym return, sport drills, carrying loads, longer community walking, floor transfers, or uneven-ground mobility. The final stage matters because many people stop too soon once pain is lower, even though they are not yet ready for full demand.

Setbacks are common in rehabilitation. Swelling may rise after doing too much. A new exercise may cause temporary soreness. Confidence may drop after one awkward movement. These setbacks do not always mean damage. Good rehabilitation teaches the person how to respond. Often the answer is to adjust the load, review technique, and keep moving in a sensible way rather than stopping completely.

Common surgery pathways include joint replacement, anterior cruciate ligament reconstruction, rotator cuff repair, fracture fixation, spinal procedures, and tendon repair. Each has its own precautions and expected milestones. However, some principles are shared across all of them: protect healing tissue, restore movement gradually, rebuild strength, practise functional tasks, and progress according to both tissue healing and individual response.

Injury rehabilitation also varies. A mild ankle sprain may need only short-term support and progressive balance work. A significant fracture or tendon rupture may need a much longer staged program. Sports injuries often require careful progression into cutting, jumping, or change-of-direction work. Workplace injuries may need ergonomic review and graded return to duties. Therapy must fit the demands the person will go back to.

Psychology matters in rehabilitation. After an injury, many people no longer trust the body part. They may fear re-injury, avoid loading it, or move differently long after healing. This is especially common after falls, major pain episodes, or traumatic injury. Good therapy uses education and graded practice to rebuild trust in the body.

Safe Hands Support can add value in this phase by helping translate rehab goals into daily routine. For example, if the program requires regular walking, supported meal preparation, or

correct use of equipment, those actions can be reinforced outside formal therapy sessions. Rehabilitation works best when the daily environment supports the same plan.

Rehabilitation milestones are not identical for everyone

Two clients with the same surgery can progress differently because of age, previous fitness, swelling response, confidence, sleep quality, and how consistently they can practise their program. Timelines guide care, but the person's response still matters.

Table 8. Common rehab stages

Stage	Main focus
Early	Protection, pain and swelling management, safe transfers, basic mobility
Middle	Range restoration, control, walking quality, foundational strength
Late	Function, endurance, stairs, return to work or recreation, confidence under load

9. Physical therapy for common body regions

Although physical therapy treats the whole person, it is useful to understand how common body regions are often approached in practice. The exact treatment depends on diagnosis and assessment findings, but some broad patterns are helpful.

Neck problems commonly involve stiffness, postural strain, reduced rotation, headaches related to neck tension, or pain that affects work, sleep, and driving. Therapy may include movement exercises, postural education, strengthening around the shoulder blades and deep neck flexors, mobility work, and advice about work setup and pacing. When symptoms travel into the arm or include numbness or weakness, further medical assessment may be needed.

Shoulder problems often affect dressing, reaching, lifting, and sleeping. Common issues include rotator cuff irritation, frozen shoulder, instability, tendinopathy, or post-surgical weakness. Therapy may focus on restoring range, improving scapular control, strengthening the rotator cuff and surrounding muscles, and gradually reintroducing overhead activity. Shoulder recovery can be slower than clients expect, so education is important.

Low back pain is one of the most common reasons people attend physical therapy. Not all back pain is the same. Some people need help with mobility and stiffness. Others need strength and endurance. Others need confidence-building, pacing, and education around persistent pain. Walking, trunk control, hip strength, lifting technique, and graded activity are often important parts of care. Serious symptoms such as new bowel or bladder changes, saddle numbness, significant weakness, or unexplained systemic symptoms need urgent medical review.

Hip problems can affect walking, stairs, rising from chairs, and balance. Therapy may involve strengthening the gluteal muscles, improving hip mobility, retraining gait, and reducing compensatory movement patterns. Hip weakness frequently affects knee and back mechanics as well, which is why the area is so important.

Knee problems are extremely common and include osteoarthritis, ligament injury, patellofemoral pain, meniscal symptoms, post-surgical weakness, and general deconditioning. Therapy often focuses on quadriceps strength, hip strength, walking mechanics, step control, balance, swelling management, and restoring confidence in bending and weight bearing.

Ankle and foot problems can change the whole movement chain. After a sprain, people often recover basic walking but still have poor balance and reduced confidence on uneven ground. Persistent calf weakness or stiffness can also affect stairs and push-off during walking. Therapy may include mobility, calf strengthening, balance retraining, foot intrinsic work, and gradual return to sport or work demands.

Hand and wrist issues may require more specialised upper-limb or hand therapy input, especially after fractures, tendon problems, nerve symptoms, or surgery. However, general physical therapy principles still apply: swelling control, movement restoration, gradual strengthening, functional use, and task modification during recovery.

Pelvic floor physical therapy is another important area, although it is often less openly discussed. It may help with continence issues, pelvic pain, recovery after birth, or pelvic floor dysfunction. This demonstrates again that physical therapy is much broader than many people first assume.

For Safe Hands Support, the key message is not to self-diagnose too narrowly. The person may complain about one body part, but the movement problem may involve related regions. A sore knee can be influenced by hip weakness. A shoulder issue can be affected by thoracic posture. A fall may relate to ankle strength, vision, and home setup all at once.

Table 9. Common body-region themes

Region	Common functional issues	Typical therapy themes
Neck	Driving, desk work, headaches, turning	Posture, mobility, control, endurance
Shoulder	Dressing, reaching, lifting, sleep	Range, cuff strength, scapular control
Back	Bending, lifting, standing, walking	Graded activity, strength, pacing, confidence
Hip/Knee	Stairs, transfers, walking, balance	Strength, gait, mobility, task practice
Ankle/Foot	Uneven ground, push-off, balance	Mobility, calf strength, single-leg control

10. Chronic conditions and long-term management

Not every physical therapy client is recovering from one short-term event. Many people live with chronic conditions that require ongoing management. In these situations, the goal is often to improve function, reduce symptom flares, maintain independence, and slow decline rather than to completely remove the condition.

Arthritis is a good example. The joint may have structural changes that are not fully reversible, but exercise, pacing, strengthening, mobility work, weight-bearing tolerance training, and education can still improve pain and function significantly. Many people become less active because of arthritis pain, then get weaker and stiffer, which makes the problem feel even bigger. Therapy helps break that cycle.

Osteoporosis and frailty also benefit from guided movement. People may become fearful of activity, especially after a fall or fracture, but safe strength, balance, posture, and mobility work are important for confidence and physical reserve. The program must respect risk, but avoidance alone leads to further decline.

Neurological conditions such as stroke, Parkinson's disease, multiple sclerosis, acquired brain injury, or peripheral neuropathy often require longer-term physical therapy input. Therapy may focus on gait, transfers, balance, endurance, tone management, coordination, cueing, compensatory strategies, and maintaining participation in meaningful tasks. Progress may be slower or more variable, but consistency still matters greatly.

Persistent pain conditions require a thoughtful approach. When pain has lasted a long time, the person may become trapped in a pattern of overactivity on good days and recovery crashes on bad days. They may also lose trust in the body and reduce their world to avoid symptoms. Therapy for persistent pain often includes education, graded exercise, pacing, sleep and recovery strategies, flare-up plans, and confidence-building rather than a search for one magic technique.

Deconditioning is another very common chronic issue. After long periods of illness, low activity, depression, repeated pain episodes, or social isolation, people can lose strength, endurance, and tolerance for basic tasks. They may feel breathless, heavy, slow, and less stable. Therapy helps rebuild capacity gradually. It is often the accumulation of small, consistent wins that changes life the most.

Long-term management usually needs routine. A person may not need formal therapy forever, but they often need a maintenance pattern. This may include a home exercise plan, walking targets, strength sessions, balance drills, pacing strategies, and regular review when setbacks occur. Good therapy therefore prepares the person for self-management, not dependence.

Carers and support workers are especially important in long-term management. Short appointments alone rarely change a person's day-to-day behaviour. Daily prompts, encouragement, support with safe setup, transport to sessions, and understanding how to grade activity can have a major effect on outcomes. Long-term management is usually a team effort.

At Safe Hands Support, chronic-condition care should focus on sustainable habits. Improvement is not always dramatic, but maintaining mobility, reducing falls, slowing decline,

and protecting confidence are major achievements. For many clients, staying active and involved in life is the real success marker.

Table 10. Long-term management priorities

Condition pattern	Useful approach
Arthritis and stiffness	Regular movement, strengthening, pacing, confidence with loading
Frailty and falls risk	Strength, balance, transfer practice, safe home setup
Persistent pain	Education, graded activity, routine, flare-up planning
Neurological change	Cueing, repetition, task practice, equipment review
Deconditioning	Slow capacity rebuilding and repeated functional practice

11. Mobility aids, equipment, and home setup

Mobility aids and supportive equipment can make movement safer, more efficient, and less exhausting. They are not signs of failure. When used appropriately, they support independence and reduce risk. However, the right aid must match the person and the environment.

Common mobility aids include single-point sticks, quad sticks, forearm crutches, frames, rollators, wheelchairs, transfer devices, and orthoses. Each has a different purpose. A person who only needs mild confidence support outdoors may not need the same device as someone with major balance loss or significant lower-limb weakness. The wrong aid can be tiring, awkward, or unsafe.

Fit matters. If a walking stick or walker is too high or too low, the person's posture and load transfer are affected. If a device is too heavy or too wide for the home environment, it may be underused. If the person does not understand when and how to use it, the benefits drop quickly. Training should include turning, negotiating doorways, sitting, standing, carrying small items, and moving over common surfaces.

Home setup is equally important. Physical ability and environment interact constantly. A cluttered hallway, low armchair, slippery bathroom floor, poor lighting, or loose rug can turn a manageable mobility issue into a significant fall hazard. On the other hand, a few well-chosen modifications can greatly improve independence.

Useful equipment may include grab rails, shower chairs, raised toilet seats, bed rails where appropriate, non-slip mats, transfer benches, long-handled aids, supportive seating, and step modifications. Equipment needs to suit the person's body size, movement ability, cognition, and routine. More equipment is not always better. The aim is a setup that supports function without creating confusion or dependency where it is not needed.

Therapists often think in terms of effort and energy cost as well as safety. If a person can technically walk to the bathroom but becomes dangerously fatigued or unstable by the return trip, the solution may include graded exercise plus temporary support. Preserving energy is especially important in people with neurological conditions, chronic illness, or severe deconditioning.

Footwear should also be considered part of equipment. Loose slippers, worn soles, poor grip, and badly fitting shoes increase fall risk and may worsen gait. Stable, secure footwear with good fit is often a simple but powerful intervention.

Transport and community access deserve attention too. Getting to appointments, entering vehicles, managing kerbs, handling ramps, and tolerating longer outings may all require planning. For some clients, therapy success is not just what happens inside the home, but whether they can rejoin community life safely and confidently.

At Safe Hands Support, home observation can provide useful information. Staff may notice whether the client furniture-walks, struggles with thresholds, avoids certain rooms, or becomes unsafe during fatigue. These observations help therapy recommendations become more accurate and practical.

Table 11. Equipment questions to check

Question	Why it matters
Is the aid the right height and type?	Poor fit changes posture and safety.
Can the person use it consistently in narrow spaces?	An aid that does not fit the real home may be abandoned.
Does the client know how to turn and sit with it?	Technique matters as much as the device itself.
Are lighting and pathways adequate?	Environment can cancel out the benefit of good equipment.

12. Home exercise programs and adherence

Home exercise programs are one of the most important parts of physical therapy. A therapist might see a person once or twice a week, but recovery and improvement happen through repeated practice over time. This is why home programs matter so much. They turn treatment from something that happens in a session into something that changes daily life.

A good home exercise program is clear, realistic, and matched to the person's goals and abilities. It should not feel like a random list of exercises copied from a handout. The person should know why each exercise is included, how often to do it, what it should feel like, what mistakes to avoid, and when to stop or seek advice.

Simplicity improves adherence. Many clients do better with a short, focused list done consistently than with a very long list that becomes overwhelming. Three to six exercises, clearly explained and linked to the person's main goals, often work better than a large routine that is difficult to remember or fit into the day.

Routine is powerful. The easiest program to follow is one linked to existing habits. Examples include doing exercises after brushing teeth, before showering, during a television ad break, after breakfast, or before the evening meal. The exact time matters less than making it repeatable. A person who waits for motivation often misses sessions. A person who has a routine tends to keep going.

Progress tracking also helps. Clients can record pain levels, repetitions, walking time, balance holds, or how confident they felt. This makes change visible. Many people feel they are not improving because day-to-day differences are small. A weekly record often shows clear progress that memory alone misses.

Barriers to adherence are common. These may include pain flare-ups, poor understanding, fear of doing it wrong, fatigue, low motivation, memory issues, depression, competing responsibilities, or lack of help with setup. Good support teams do not blame the client for these barriers. They work around them. Sometimes the answer is reducing the program. Sometimes it is adding reminders. Sometimes it is reviewing technique. Sometimes it is changing the time of day.

Carers and support workers can strongly improve adherence when their role is respectful and practical. Helpful support may include setting up a safe space, reminding the client, encouraging rest between sets, observing for obvious fatigue or instability, or reinforcing why the program matters. Unhelpful support would be rushing the person, forcing high effort on bad days, or changing the program without clinician guidance.

One useful principle is minimum effective dose. On difficult days, doing a reduced version may be better than doing nothing. For example, one walking circuit instead of three, or one set instead of two, can help maintain routine and confidence. This prevents the all-or-nothing pattern that often damages progress.

Therapists also need to update home programs. As the person improves, the exercises should progress. If the program stays the same forever, it may become too easy or no longer match the person's goals. Regular review keeps the program purposeful.

At Safe Hands Support, home programs should be treated as part of everyday support planning, not as an extra task added only when convenient. When the environment supports consistency, therapy outcomes improve significantly.

Table 12. Common barriers to home exercise

Barrier	Helpful response
Too many exercises	Simplify the program and focus on high-value tasks.
Fear of doing it wrong	Review technique and provide clearer cues.
Pain flare-ups	Use a graded plan and define acceptable symptom response.
Low motivation	Link exercises to meaningful goals and build routine.
Memory issues	Use written prompts, charts, or carer reminders.

13. What to expect in sessions

Many people feel more confident with physical therapy when they know what sessions are likely to involve. Although each provider works differently, sessions usually follow a logical pattern and become more tailored over time.

The initial evaluation is often the longest session. It usually includes discussion of the problem, review of symptoms and history, observation of movement, physical testing, explanation of findings, and early planning. The therapist may not do every possible treatment in the first visit because understanding the problem properly is the priority. The session may also include education about safety, expected progress, and what the client should start doing at home.

Follow-up sessions often begin with a short review. The therapist may ask how the person felt after the last session, whether exercises were manageable, whether there were any flare-ups, and what changes have been noticed in function. This is important because treatment should respond to the person's real experience, not just the original plan.

The active part of the session may include exercise practice, progression of the home program, gait or transfer training, strength work, balance drills, mobility work, breathing strategies, or task-specific training such as stair practice or getting in and out of a vehicle. Some sessions may also include manual therapy, taping, education, or equipment review.

Rehabilitation is rarely the same in every session. Early sessions may be more focused on pain control, mobility, and reassurance. Middle sessions often increase strengthening and movement challenge. Later sessions may become more functional and demanding, especially if the goal is returning to work, sport, or full community independence.

The frequency of sessions varies. Some people need more frequent sessions early in recovery. Others do well with less frequent review if they are able to complete their home program independently. More sessions do not always mean better results. What matters is whether the program is appropriate and whether it is being carried into daily life.

Clients should also expect some monitoring of progress. This may involve repeated measures, observation of walking, checking range of motion, tracking balance tasks, or discussing how daily activities have changed. Good therapy makes progress visible.

Communication matters throughout. Clients should feel comfortable asking what an exercise is for, what level of discomfort is acceptable, how to manage a flare-up, and how to fit the plan into their daily routine. Therapy tends to work better when the person is engaged and informed rather than simply told what to do.

Discharge is also part of good therapy. Discharge does not mean the therapist no longer cares. It means the person has enough skill, confidence, and plan structure to continue independently or with lower-level support. Sometimes discharge includes a maintenance program. Sometimes it includes advice to return if certain triggers occur.

At Safe Hands Support, understanding session structure helps support workers reinforce the same plan. If a therapist is focusing on walking quality, pacing, and safe transfers, daily support should not push in the opposite direction. Consistency between sessions and everyday care improves results.

Table 13. What a session may include

Part of session	Purpose
Review	Check response since last visit and identify barriers.
Exercise practice	Develop strength, movement quality, and confidence.
Task training	Improve daily function such as stairs or transfers.
Education	Support self-management and explain expectations.
Progression plan	Make sure the home program continues moving forward.

14. Working with carers and support workers

Physical therapy is often more successful when carers, family members, and support workers understand the treatment goals and the person's functional needs. They do not replace the therapist, but they can make the therapy plan much more effective by reinforcing it safely.

Support workers often see the person during real-life tasks: waking, showering, toileting, dressing, meal preparation, community access, transfers, and fatigue periods later in the day. This means they can notice practical barriers that may not appear fully during an appointment. Examples include unsafe bathroom turning, difficulty rising from a couch, slowing gait in the evening, increased hesitation near stairs, or inconsistent use of a walking aid.

One key role is observation and reporting. Support staff can note what the person manages independently, what level of prompting helps, what activities trigger pain or fatigue, whether there were near-falls, and whether exercises are being completed. This information helps the therapist fine-tune the program. Clear, factual reporting is more helpful than vague statements like "they seemed worse".

Another role is safe prompting. Some clients benefit from reminders to use their program, pacing advice, encouragement to take rest breaks, or cueing for technique that has been specifically taught by the therapist. However, support workers should stay within their scope. They should not invent exercises, progress resistance independently, or push through warning signs without guidance.

Motivation support matters too. Recovery can be slow, and people may become discouraged. Support staff can help by linking exercises to meaningful goals, recognising small wins, and keeping the tone calm and encouraging rather than pressuring. The aim is to build confidence, not to make the client feel judged.

Environmental setup is another important contribution. Staff can make sure the exercise area is clear, that chairs and aids are positioned safely, that footwear is appropriate, and that the person is not attempting difficult tasks when very fatigued or distracted. These practical details often determine whether the plan is followed well.

Respect for client autonomy is essential. Support should aim to maximise the person's own ability. Doing too much for someone can reduce confidence and decondition them further. Good support involves finding the right level of assistance: enough to keep the person safe, but not so much that it removes meaningful movement opportunities.

Communication with the broader team is also important. Therapists, support coordinators, family, nursing staff, and medical practitioners may all be involved. When the team shares the same understanding of goals, equipment, precautions, and functional priorities, care becomes smoother.

For Safe Hands Support, this chapter is especially relevant. Support staff are often the bridge between clinic recommendations and real daily action. When staff understand why a person is practising sit-to-stands, pacing walking, or using a frame in a certain way, the entire support environment becomes more therapeutic.

Helpful phrases support workers can use

- Let’s set this up so it is safe and easy to start.
- How did the exercise feel last time and what changed after?
- Would you like to do the first set now and the second after a short break?
- You needed less help with that transfer today.

15. Safety, warning signs, and when to seek medical help

Physical therapy is generally very safe when it is individualised and delivered appropriately, but safety must always stay central. Not every symptom is routine rehabilitation discomfort. Clients, carers, and support workers should know the difference between expected recovery responses and warning signs that need medical attention.

Some mild responses can be normal. Examples include gentle muscle soreness after new strengthening work, temporary fatigue after exercise, mild stiffness the next morning, or a short-lasting increase in symptoms that settles within a sensible period. These responses often reflect adaptation. However, the response should be proportionate and should not cause major loss of function.

Warning signs may include severe or rapidly worsening pain, unexplained swelling, redness and heat that are increasing, sudden loss of strength, new numbness or tingling that is spreading, joint locking, repeated giving way, dizziness with falls, chest pain, shortness of breath that is new or severe, calf swelling with pain, wound problems, fever, or major decline in mobility. These situations may require urgent review by a doctor or emergency care depending on severity.

Some body regions have specific red flags. New bowel or bladder changes with back symptoms, saddle numbness, or severe neurological changes need urgent medical assessment. Head injury after a fall should never be ignored. Sudden inability to weight bear after a traumatic event also needs review. After surgery, unexpected wound leakage, increasing calf pain, or symptoms of infection are important to escalate.

Exercise safety also involves correct dose. More is not always better. People often flare because they combine therapy exercises with a very busy day of walking, housework, shopping, and stairs, then assume the exercise alone caused the problem. Load must be looked at as a whole day, not just as one program sheet.

Hydration, appropriate footwear, safe surfaces, lighting, and supervision level also affect safety. Balance work should be done in a setup that allows support if needed. Walking aids should be checked regularly. Resistance bands and home equipment should be in good condition and used as instructed.

Consent and comfort matter. The client should understand what the session involves and should feel able to say when something feels wrong. Therapy should challenge the body, but it should not ignore the person’s feedback.

For support staff, clear documentation and escalation pathways are essential. If a client has an unusual pain response, a near-fall, or a major drop in function, this should be recorded clearly and passed on to the right clinician or manager. Early escalation can prevent a small issue becoming a major setback.

At Safe Hands Support, a safe therapy culture means encouraging movement while also respecting signs that medical review is needed. The aim is confident, informed activity, not reckless activity and not unnecessary avoidance either.

Table 14. Expected responses versus warning signs

Expected or manageable	Needs prompt review
Mild muscle fatigue after new exercise	Sudden major loss of strength or function
Short-lived increase that settles	Escalating swelling, redness, or heat
Manageable soreness after progression	Chest pain, severe breathlessness, or collapse
Need for a lighter day after a busy day	New neurological symptoms or severe instability

16. Practical checklists, logs, and planning tools

Education becomes much more useful when people can turn it into action. This chapter provides practical tools that can be used by clients, carers, families, and support staff to organise recovery and support consistency. These tools are not rigid rules. They are guides that help people notice patterns, set priorities, and keep therapy connected to daily life.

A recovery checklist can help after surgery, injury, or a decline in mobility. It might include pain control, swelling observation, safe transfers, use of walking aids, hydration, medication timing, exercise completion, walking targets, sleep quality, and confidence levels. Reviewing the same checklist daily or weekly can make small progress easier to see.

Activity planning is especially helpful for people with pain flare-ups, fatigue, or inconsistent pacing. A person may think they are inactive, but when the day is mapped out they may realise they are doing too much in one block and then crashing later. Breaking large tasks into smaller parts, alternating sitting and standing, spreading community activities through the week, and building planned rest periods often improves function without reducing total participation.

Walking logs are simple and effective. Recording distance, minutes, rest breaks, confidence, and symptom response gives a clearer picture than guessing. A walking log can also show whether the person is gradually improving, plateauing, or overshooting on good days. The same idea can be used for stairs, standing tolerance, sit-to-stands, or shoulder repetitions.

Home setup checklists can reduce risk quickly. Common items include clear walkways, stable furniture height, bathroom access, non-slip surfaces, lighting, rail availability, footwear, bed transfer setup, and safe storage of frequently used items. These details are easy to overlook because they become normal to the household, but they can have a major effect on function and falls risk.

Exercise planners are useful too. They should answer five questions: what to do, how many, how often, what it should feel like, and what to do if symptoms rise. Many clients stop exercise because they are unsure, not because they are unwilling. Clear planning reduces uncertainty.

A flare-up plan is another valuable tool. This may include reducing activity volume temporarily rather than stopping completely, using simple pain-relief strategies advised by the clinician, focusing on gentle movement, returning to the usual program gradually, and knowing when to seek review. Flare-ups are easier to manage when there is a plan in advance.

For Safe Hands Support, practical tools also help team communication. Different workers can see the same goals, the same setup, and the same cues that help the client. This makes support more consistent and reduces mixed messages.

The worksheets in this chapter are meant to be adapted. Some clients will prefer very simple one-page forms. Others may benefit from more detailed weekly logs. The main point is to make progress visible, routine-based, and linked to real function.

Practical tool 1: daily recovery checklist

Checklist item	Yes/No/Notes
Pain level is manageable for today’s tasks	
Swelling or redness has not worsened	

Checklist item	Yes/No/Notes
Walking aid or equipment is set up correctly	
Home exercise program completed or modified safely	
Walking or mobility target attempted	
Hydration, meals, and rest were adequate	
No falls or near-falls today	
Any change has been reported to the right person	

Practical tool 2: weekly walking log

Day	Minutes walked	Rest breaks	Confidence /10	Symptoms after
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Practical tool 3: home setup safety check

Area	What to check	Action needed
Bedroom	Clear path to bed and night light available	
Bathroom	Non-slip setup and safe turning space	
Living room	Chair height and clutter-free pathways	
Kitchen	Frequently used items at easy reach	
Entry/outdoor area	Safe step access and stable footwear	

Exercise library

The following exercise descriptions are examples only. A qualified therapist should decide which ones are appropriate for a specific client, how many repetitions should be used, and whether precautions apply.

Sit-to-stand

Improves leg strength, transfer ability, and confidence getting out of chairs. Start from a stable chair with feet under the knees, lean slightly forward, and stand using the legs as much as possible. Sit back down with control rather than dropping quickly. Common mistakes include pushing heavily through the arms when not needed, knees collapsing inward, and rushing the lowering phase. Progression may include lowering the chair height, reducing hand support, pausing at the bottom, or increasing repetitions.

Supported heel raises

Builds calf strength for walking, stairs, and balance recovery. Stand behind a bench or kitchen counter, rise onto the balls of the feet, hold briefly, then lower slowly. The movement should be controlled and upright. Progressions include single-leg versions, slower lowering, or holding longer at the top. This exercise is useful after ankle injury and in general balance programs.

Marching on the spot

Helps with hip flexor strength, single-leg balance tolerance, and stepping confidence. Stand tall with support nearby and lift one knee at a time. It can be used as a warm-up, balance task, or endurance drill. Progressions include reduced hand support, slower control, or combining with cognitive tasks such as counting backwards.

Mini squat

Targets the hips and knees in a practical movement pattern. With feet hip-width apart, bend the hips and knees a small amount as though about to sit, then return to standing. The chest stays lifted and the knees track over the feet. This is useful for stair ability, lifting, and general lower-limb strength. It should be pain-managed carefully for people with irritated knees.

Bridge

Improves hip and trunk strength. Lying on the back with knees bent, tighten the glutes and lift the hips from the bed or mat, then lower slowly. Common goals include pelvic control, reduced deconditioning, and improved bed mobility. It can progress to longer holds, single-leg control, or band resistance depending on the person.

Straight-leg raise

Often used early after knee surgery or when quadriceps control is reduced. With one knee bent and the other straight, tighten the front thigh and lift the straight leg a short distance. The knee should stay straight. This exercise is useful when weight-bearing is limited or when rebuilding control around the knee.

Clamshell

Targets the outer hip muscles that support pelvis control and lower-limb alignment. Lying on the side with knees bent, keep the feet together and lift the top knee without rolling the trunk backwards. This exercise is common in programs for hip weakness, knee pain, and walking control.

Step-up

A functional strengthening exercise for stairs, community access, and confidence. Step onto a low platform or stair, push through the whole foot, straighten fully, then step down with control. Height and speed are adjusted to the client’s level. Poor control during the lowering phase often shows the person’s true strength level.

Tandem stand

A static balance drill where one foot is placed directly in front of the other. It narrows the base of support and challenges postural control. The client should perform it near a support surface. Progressions include head turns, longer holds, or eyes-closed versions when clinically appropriate.

Single-leg stand

Used for balance, ankle strategy, and hip control. The person stands on one leg while keeping posture tall and using nearby support if needed. This exercise is common in falls prevention and lower-limb rehabilitation. Time-based progressions are often used.

Wall slide

Encourages shoulder movement in a supported way. The hand or forearm slides up a wall while the person keeps the shoulder relaxed and the body aligned. It is often used after shoulder pain or stiffness to reintroduce range without heavy resistance.

Scapular retraction

Strengthens the muscles around the shoulder blades and supports posture. The person gently draws the shoulder blades back and down without shrugging. It is often included in neck and shoulder programs, especially for people who spend long periods sitting.

Chin nod

Targets deep neck control rather than large neck movement. The person gently nods as if making a small double chin without lifting the head. It is often useful in neck pain programs where posture and motor control need improvement.

Pelvic tilt

A simple early trunk and awareness exercise. Lying on the back with knees bent, the person gently rocks the pelvis to flatten and release the low back. It may help with early mobility, comfort, and control after back pain or prolonged inactivity.

Knee extension stretch

Improves the ability to fully straighten the knee, which is crucial for normal walking. Methods vary, but a common approach is supporting the heel while allowing the knee to straighten gently. This should be progressed carefully if pain or post-operative precautions are present.

Hamstring stretch

Targets the back of the thigh and may be used when flexibility limits bending or walking comfort. It should be gentle and steady rather than aggressive. Stretching is most useful when it addresses a real restriction rather than being added automatically.

Calf stretch

Improves ankle flexibility and can assist with walking mechanics and stair performance. The person leans into a wall with one leg back and heel down, or uses a step-based version if appropriate. Tight calves often contribute to altered gait.

Thoracic extension over chair

Supports upper-back mobility, posture, and overhead function. The person leans gently back over the top of a stable chair while supporting the head if needed. It can be useful for people with rounded sitting posture and shoulder restriction.

Seated knee march

A lower-demand exercise for clients with reduced standing tolerance. It encourages hip flexion, circulation, and active movement while seated. It may be useful early after illness or for deconditioned clients.

Walking intervals

A practical endurance tool. The person alternates a set walking time with a short rest, repeating several rounds. This helps build capacity gradually and is often easier to manage than one long continuous walk.

Side stepping

Improves lateral hip strength and balance strategy. The person steps sideways along a bench or hallway with control, keeping toes forward. This is helpful because many falls occur during side movements or direction changes.

Toe taps to step

A balance and coordination drill where the person alternates tapping one foot onto a low step. It challenges weight transfer, hip control, and safe stepping. Support can be reduced over time.

Reaching in standing

The client practises reaching for objects at different heights and directions while maintaining balance. This links therapy to daily life and is useful for kitchen tasks, dressing, and bathroom independence.

Bed mobility drill

Rolling, bridging, and moving up the bed are practised as exercises when bed mobility is reduced. This is especially important after surgery, illness, or major deconditioning because bed independence strongly affects dignity and care needs.

Sit balance training

Used when standing is not yet safe or when trunk control is reduced. The person practises upright sitting, reaching, and maintaining posture without excessive support. This can be an early step toward standing and transfers.

Condition-specific quick guides

Arthritis

Focus on regular movement, lower-limb strength, pacing, and preserving confidence. Flare-ups may require temporary load reduction rather than stopping all activity. Support should encourage mobility while respecting pain patterns and fatigue.

Low back pain

Look at walking tolerance, trunk and hip capacity, lifting habits, sitting time, and fear of movement. Useful support includes pacing, avoiding long immobile periods, and reinforcing graded activity rather than bed rest.

Shoulder pain

Watch how the person dresses, reaches, carries, and sleeps. Range work and controlled strengthening are often needed. Reaching tasks may need height adjustment early in recovery.

Knee osteoarthritis

Sit-to-stands, step practice, quadriceps and hip strength, walking pacing, and weight-bearing confidence are commonly important. Stairs and low seating often reveal functional limitation.

Post-fracture recovery

Follow weight-bearing advice carefully, monitor swelling and confidence, and progress from basic transfers to full functional loading over time. Avoid assuming pain-free equals fully healed.

Neurological balance problems

Clear pathways, cueing, repetition, and supervised balance practice are important. Fatigue, attention, and sensory issues may affect performance from one time of day to another.

Frailty

The main aims are safe strength, transfer ability, walking confidence, and energy conservation. Even small gains in standing tolerance or repeated chair rises can significantly improve independence.

Persistent pain

Use pacing, regular routine, sleep support, gradual movement exposure, and calm reassurance. Avoid all-or-nothing activity patterns and avoid equating every symptom increase with harm.

Post-hospital weakness

Start with simple daily function targets: bed mobility, bathroom access, meal-time walking, and standing tolerance. A little done often is usually better than one exhausting effort.

Falls history

Review footwear, urgency to toilet, nighttime lighting, turning speed, walking aid use, and lower-limb strength. Near-falls are important warning signs, not minor details.

Sample weekly plans

Weekly plan A: early post-surgery support

Time / Day	Suggested focus
Morning	Ankle pumps, gentle range exercises, short indoor walk, pain and swelling check.
Midday	Rest with leg supported if advised, hydration, sit-to-stand practice, short walk.
Afternoon	Home exercise program, walking aid review, stair practice only if cleared.
Evening	Light walk, cold or elevation if advised, prepare for safe night-time toileting.

Weekly plan B: deconditioning rebuild

Time / Day	Suggested focus
Day 1	3 rounds of 3-minute walking plus seated strengthening.
Day 2	Mobility and breathing work with lighter walking.
Day 3	Repeat walking intervals and add extra sit-to-stands if tolerated.
Day 4	Active recovery with short household movement spread through the day.
Day 5	Walking intervals, balance practice, and upper-limb tasks.
Day 6	Light activity focus and social/community participation.
Day 7	Review fatigue, confidence, and total weekly activity.

Weekly plan C: falls-prevention focus

Time / Day	Suggested focus
Most days	Walking plus sit-to-stands and heel raises.
3 days per week	Balance drills such as tandem stand, toe taps, and turning practice.
Daily habits	Check lighting, footwear, and bathroom safety setup.
Weekly review	Record any near-falls, hesitations, or changes in confidence.

Weekly plan D: persistent pain pacing plan

Time / Day	Suggested focus
Base activity	Choose a level of walking or chores that is manageable on most days.
Build slowly	Increase only when the base feels steady for at least several days.
Flare-up days	Reduce volume, keep gentle movement, avoid total bed rest if safe.
Recovery	Return to the baseline plan before progressing again.

Support worker cue cards

Cue card 1: transfers

Ask the client to bring their feet back, lean forward, and push through the legs. Give enough time for the movement rather than rushing.

Cue card 2: walking aid use

Make sure the aid is within reach before standing. Encourage upright posture and safe turning rather than twisting quickly.

Cue card 3: pacing

Break bigger tasks into smaller parts. A slower steady approach usually produces better function than one large effort followed by a crash.

Cue card 4: balance safety

Practice balance tasks near stable support. Remove clutter and avoid distractions when challenge is increased.

Cue card 5: exercise reminders

Use calm prompts linked to routine. Ask whether the client wants to do their exercises after breakfast or before the shower rather than using vague reminders.

Cue card 6: pain flare response

Reduce the volume for a short period, keep gentle movement going, and monitor for warning signs. Do not jump straight from flare-up to full inactivity.

Cue card 7: confidence building

Notice small wins. Saying 'you stood up with less help today' is more motivating than general encouragement alone.

Cue card 8: fatigue awareness

Observe whether movement quality drops later in the day. Some tasks may be safer earlier when the client is less tired.

Cue card 9: home setup

Keep frequently used items easy to reach and maintain clear walking paths, especially to the bathroom and bedroom.

Cue card 10: escalation

Report near-falls, repeated pain spikes, new swelling, marked decline, or major confusion about the therapy plan early rather than waiting.

Additional planning pages

Goal	Why it matters	How we will measure progress	Review date

Goal	Why it matters	How we will measure progress	Review date

Goal	Why it matters	How we will measure progress	Review date

17. Frequently asked questions

Clients and families often have similar questions when starting physical therapy. Answering these clearly can reduce fear and improve follow-through.

One common question is whether exercise should hurt. The answer depends on the condition, the stage of recovery, and the intensity of the exercise. Mild discomfort or effort can be normal. Severe pain, sharp instability, or symptoms that keep escalating are not the goal. The client should know their own boundaries and the clinician should explain acceptable responses clearly.

Another question is how long recovery takes. There is no single answer. Recovery depends on tissue type, severity, age, general health, consistency with the program, confidence, and the demands the person is trying to return to. What matters most is steady progress in function, not comparing timelines with someone else.

People also ask whether rest is better than movement. In some early situations, short-term protection is necessary, but complete rest for too long often leads to stiffness, weakness, and slower recovery. In many conditions, the body improves through appropriate movement rather than by waiting for perfect comfort before moving again.

Some clients worry that using a walking aid means they are getting worse. In reality, a walking aid can be a smart short-term or long-term strategy depending on the person's needs. The question is not pride. The question is whether it improves safety, confidence, and efficiency.

Another frequent question is whether home exercises really matter. They do. Sessions alone rarely create enough repetition to change strength, endurance, balance, and movement habits. The home program is usually where the majority of improvement is built.

Clients may also ask what to do if they miss a few days. In most cases, the best response is to restart gently rather than give up. One interruption does not ruin progress. Consistency over months matters more than perfection every single day.

Families often ask how much help they should provide. The answer is enough help for safety and success, but not so much that the person loses opportunities to move and practise. Support should build ability, not replace it.

People also ask when they should go back for review. Common reasons include worsening symptoms, repeated falls or near-falls, inability to progress, confusion about the program, major change in function, new pain after an event, or return of a problem that had previously settled.

At Safe Hands Support, answering these common questions in a calm and practical way can reduce anxiety and improve engagement with therapy.

Extended questions and answers

Do I need to be in pain before I ask for help?

No. Therapy can be useful for prevention, movement decline, reduced confidence, and function problems even before severe pain develops.

Can older adults still improve balance and strength?

Yes. Improvement may be gradual, but older adults can still gain strength, mobility, and confidence with appropriately prescribed exercise.

What if I feel tired more than sore after therapy?

Fatigue can be part of recovery, especially after illness or inactivity. The plan may need pacing adjustments, but some tiredness is not unusual.

Should every exercise feel easy?

Not necessarily. Exercise should be challenging enough to create change, but still safe and manageable.

Why am I doing hip exercises when my knee hurts?

Because body regions work together. Hip weakness can increase strain around the knee and affect walking and stair control.

What if I am scared of falling during exercises?

That should be taken seriously. Exercises can be modified with support surfaces, supervision, and a safer setup so confidence builds gradually.

How often should I review my program?

This depends on the condition, but review is helpful whenever progress stalls, symptoms change, or exercises become too easy.

Can a support worker do the exercises for me?

No. They can assist with setup, reminders, and safety, but the aim is for you to do as much active movement as you safely can.

Case examples

Case example 1: older adult after a fall

A 78-year-old client reports one fall in the bathroom and two recent near-falls when turning quickly. Since the fall, they avoid walking outside alone and now hold onto furniture around the house. Assessment shows reduced sit-to-stand strength, slow turning, poor single-leg balance, and low confidence. A therapy plan might include chair rises, balance drills near support, walking practice, bathroom setup changes, night-light review, and safe footwear advice. The key outcome is not only fewer falls, but restored confidence in moving around the home.

Case example 2: post-knee replacement recovery

A client after knee replacement has improving pain but still walks with a stiff leg and struggles with stairs. Therapy focuses on knee extension range, swelling control, quadriceps strength, gait retraining, and repeated step practice. At first the goal may be independent transfers and short indoor walking. Later goals may include community distances, car transfers, and return to light exercise. Daily adherence to simple home exercises often makes the biggest difference.

Case example 3: persistent low back pain

A client has had back pain for over a year and has stopped many activities through fear of making it worse. They spend long periods resting, then attempt a big day of cleaning or shopping and flare badly afterwards. Therapy may focus on education about pain, graded walking, trunk and hip strengthening, pacing, and rebuilding confidence with bending and lifting. Progress is measured by function, such as standing longer, walking more, and returning to valued tasks, rather than by chasing a pain-free body immediately.

Case example 4: shoulder stiffness affecting self-care

A client cannot comfortably reach overhead to wash hair or put on a shirt. Assessment shows limited shoulder range, weak rotator cuff function, and protective movement patterns. Therapy may combine range work, supported mobility, scapular control, and gradual strengthening. Home exercises are often short but need to be done regularly. Functional practice might include reaching to shelves, dressing motions, and controlled carrying tasks.

Case example 5: deconditioning after hospital stay

Following a prolonged hospital stay, a client is medically stable but tires quickly, needs more help with transfers, and avoids walking because it feels exhausting. Therapy may start with basic sit-to-stands, short corridor walks, breathing control, and seated strengthening. Progression may be slow but meaningful. The first wins may include standing long enough to shower more independently or walking from bedroom to kitchen without stopping.

Case example 6: ankle sprain that never fully recovered

A younger client reports the original sprain happened months ago, but the ankle still feels weak and unreliable on uneven ground. Pain is now mild, but there is recurrent rolling and reduced confidence. Therapy focuses on calf strength, ankle mobility, single-leg balance, direction change, and eventual return to sport or active recreation. This example shows that feeling 'mostly better' is not the same as fully rehabilitated.

Case example 7: Parkinsonian mobility decline

A client with Parkinsonian movement changes reports shuffling, freezing in tight spaces, and difficulty turning. Therapy may include cueing strategies, larger-amplitude movement practice, turning drills, posture work, and gait training. Support staff can help by keeping pathways clear, allowing enough time for movement, and using consistent cues taught by the therapist.

Case example 8: arthritis and reduced community participation

A client with hip and knee arthritis has become less active due to pain and now avoids community outings because they fear being too slow. Therapy may include lower-limb strengthening, walking intervals, pacing, supportive equipment review, and confidence building. The real success measure may be returning to social activity or shopping independently rather than removing every symptom.

18. Glossary and references

This final chapter explains common physical therapy terms in plain language and lists key source organisations used to shape the guide. The glossary is written for readability, not for academic complexity. The references are included so Safe Hands Support can show that the guide is based on recognised professional and public health sources rather than opinion alone.

A glossary is useful because health language can be confusing. Terms like range of motion, gait, weight bearing, deconditioning, flare-up, postural control, and functional training are common in therapy but may not be familiar to every client or family member. Understanding the language makes therapy easier to follow.

The references in this document come mainly from trusted professional associations and public health organisations with guidance relevant to physical therapy, movement, exercise, chronic pain, and falls prevention. Because individual client care must always be personalised, these references should be seen as background support for the general principles in this guide, not as replacements for an individual treatment plan.

Safe Hands Support can use this chapter at the end of the PDF to show transparency, professionalism, and commitment to evidence-based information.

Glossary

Term	Meaning
Assessment	The process of gathering information through questions, observation, and testing to understand the client's movement problem and plan treatment.
Balance	The ability to stay upright and control body position while standing, walking, turning, or reaching.
Chronic condition	A health issue that lasts a long time and often needs ongoing management rather than short-term treatment only.
Coordination	How well different body parts work together to perform a smooth movement.
Deconditioning	Loss of strength, fitness, and physical capacity due to inactivity, illness, or long periods of reduced movement.
Endurance	The ability to keep doing an activity over time without fatiguing too quickly.
Exercise adherence	How consistently a person follows their home exercise or activity plan.
Flare-up	A temporary increase in symptoms such as pain, stiffness, or fatigue.
Flexibility	How much length or freedom of movement muscles and soft tissues allow.
Function	The ability to do meaningful daily activities such as walking, dressing, cooking, working, or recreation.

Term	Meaning
Functional training	Practice of real-life tasks to improve everyday movement and independence.
Gait	A person’s walking pattern.
Goal setting	Choosing clear, meaningful targets that guide treatment and progress.
Home exercise program	A set of exercises prescribed to be done outside therapy sessions.
Manual therapy	Hands-on treatment such as mobilisation or soft tissue techniques used by a therapist.
Mobility	The ability to move around safely and effectively.
Mobility aid	Equipment such as a walking stick or frame that helps movement and safety.
Modalities	Physical agents such as heat, cold, compression, or electrical stimulation used to help symptoms in some cases.
Muscle strength	The force a muscle can produce to support movement and control.
Outcome measure	A test or questionnaire used to track change over time.
Pacing	Balancing activity and rest so the person does not overdo tasks and trigger avoidable flare-ups.
Pain management	Strategies used to reduce pain impact and improve daily function.
Physical therapy	A health profession focused on movement, function, recovery, and independence.
Posture	The way the body is aligned in sitting, standing, and moving.
Progression	Making an exercise or activity gradually more challenging as the person improves.
Range of motion	How far a joint can move in a specific direction.
Reassessment	Reviewing the person again to measure change and adjust the plan.
Rehabilitation	The process of restoring function after injury, surgery, illness, or decline.
Resistance training	Exercise that challenges muscles against a load such as body weight, bands, or weights.
Sit-to-stand	The task of rising from a chair to standing, often used as both a test and an exercise.
Stability	Control of a joint or body position during movement or loading.
Strengthening	Exercise designed to improve muscle force and control.
Support worker	A person who assists a client with daily tasks and may help reinforce therapy plans within their scope.
Therapeutic exercise	Planned exercise chosen for a specific

Term	Meaning
	treatment goal.
Transfer	Moving from one surface to another, such as bed to chair or sit to stand.
Vestibular system	The inner-ear system that helps with balance and spatial awareness.
Walking interval	A method of building endurance by alternating walking periods and rest periods.
Weight bearing	How much body weight is placed through a limb, often guided after injury or surgery.
Warm-up	Gentle activity at the start of exercise to prepare the body for movement.
Warning sign	A symptom that may indicate the need for medical review rather than routine exercise adjustment.

Reference organisations and resources

- American Physical Therapy Association and the APTA Guide to Physical Therapist Practice resources.
- ChoosePT patient education resources on balance, physical activity, and condition-specific therapy topics.
- Better Health Channel (Victoria) public information on physiotherapists, persistent pain, posture, and allied health.
- Australian Government Department of Health resources on the 24-hour movement guidelines for adults, older adults, people with disability, and people with chronic conditions.
- NHS and related UK public health resources on physiotherapy exercises and pain-related activity guidance.
- CDC resources on older adult physical activity and falls prevention.
- NICE chronic pain guidance that emphasises active management and supervised exercise for chronic primary pain.

Safe Hands Support note

This document is written as a general educational guide for Safe Hands Support. It is suitable for use as a resource-page PDF for clients, families, carers, and staff. It should be used alongside, not instead of, individual advice from a registered physiotherapist, doctor, or other qualified health professional.

Appendix A1. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A2. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A3. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A4. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A5. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A6. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A7. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A8. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A9. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A10. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A11. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix A12. Weekly exercise log

Use this page to record when exercises were completed, what felt easy or hard, and whether any changes are needed at the next review.

Day	Exercises completed	Effort /10	Symptoms after	Comments

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Appendix B1. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B2. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B3. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B4. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B5. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B6. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B7. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix B8. Walking and activity record

Track walking time, rest breaks, and confidence. This is useful for building endurance gradually and noticing patterns across the week.

Date	Minutes walked	Rest breaks	Confidence /10	Symptoms	Comments

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Appendix C1. Pain and symptom diary

This page can help identify triggers, flare-ups, and what management strategies were useful. Keep descriptions factual and simple.

Date / time	Activity at the time	Symptoms	Intensity /10	What helped	Follow-up needed

Notes:

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Appendix C2. Pain and symptom diary

This page can help identify triggers, flare-ups, and what management strategies were useful. Keep descriptions factual and simple.

Date / time	Activity at the time	Symptoms	Intensity /10	What helped	Follow-up needed

Notes:

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Appendix C3. Pain and symptom diary

This page can help identify triggers, flare-ups, and what management strategies were useful. Keep descriptions factual and simple.

Date / time	Activity at the time	Symptoms	Intensity /10	What helped	Follow-up needed

Notes:

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Appendix C4. Pain and symptom diary

This page can help identify triggers, flare-ups, and what management strategies were useful. Keep descriptions factual and simple.

Date / time	Activity at the time	Symptoms	Intensity /10	What helped	Follow-up needed

Notes:

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Appendix C5. Pain and symptom diary

This page can help identify triggers, flare-ups, and what management strategies were useful. Keep descriptions factual and simple.

Date / time	Activity at the time	Symptoms	Intensity /10	What helped	Follow-up needed

Notes:

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This page can help identify triggers, flare-ups, and what management strategies were useful. Keep descriptions factual and simple.

Date / time	Activity at the time	Symptoms	Intensity /10	What helped	Follow-up needed

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Appendix D1. Falls and near-falls observation sheet

Record all falls and near-falls, including where they happened, what the person was doing, whether an aid was used, and what action was taken afterwards.

Date	Fall / near-fall	Location	What happened	Injury	Action taken

Notes:

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Appendix D2. Falls and near-falls observation sheet

Record all falls and near-falls, including where they happened, what the person was doing, whether an aid was used, and what action was taken afterwards.

Date	Fall / near-fall	Location	What happened	Injury	Action taken

Notes:

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Notes:

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Date	Fall / near-fall	Location	What happened	Injury	Action taken

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Date	Fall / near-fall	Location	What happened	Injury	Action taken

Notes:

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Record all falls and near-falls, including where they happened, what the person was doing, whether an aid was used, and what action was taken afterwards.

Date	Fall / near-fall	Location	What happened	Injury	Action taken

Notes:

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Appendix E1. Appointment and review notes

Use this page to summarise key advice from therapy or medical appointments so all supports are working from the same plan.

Date	Provider	Main advice	Program changes	Next review

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Appendix E2. Appointment and review notes

Use this page to summarise key advice from therapy or medical appointments so all supports are working from the same plan.

Date	Provider	Main advice	Program changes	Next review

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Date	Provider	Main advice	Program changes	Next review

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Appendix E4. Appointment and review notes

Use this page to summarise key advice from therapy or medical appointments so all supports are working from the same plan.

Date	Provider	Main advice	Program changes	Next review

Notes:

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Appendix E6. Appointment and review notes

Use this page to summarise key advice from therapy or medical appointments so all supports are working from the same plan.

Date	Provider	Main advice	Program changes	Next review

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Appendix F1. Goal review worksheet

Use this sheet to review what matters most to the client, what has improved, what is still limited, and what the next therapy priority should be.

Goal	Current level	What has improved	Next step	Review date

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Appendix F2. Goal review worksheet

Use this sheet to review what matters most to the client, what has improved, what is still limited, and what the next therapy priority should be.

Goal	Current level	What has improved	Next step	Review date

Notes:

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