Revise the rehabilitation plan

Take the plan you wrote in Week 7 and make it survive review

Clinicians do not write a plan once. They write it, somebody finds the problem in it, and they revise it with a reason recorded for every change. This item is that second half, and it is the one item in the pack that needs work you already did.

90 MINUTES | TWO SITTINGS | NEEDS YOUR WEEK 7 PLAN | VALUE ANNOUNCED WHEN THE PACK OPENS

WHAT THIS ITEM IS WORTH

The point value is announced when the pack opens, printed on the portal beside the item and written on the board. It is not printed here, because the value is set once and printing it in two places is how two different numbers end up in circulation.

What is fixed now is the **size**. This page tells you how long the work takes and what you have to produce. Read that first and decide whether you have the time before you start.

CHECK THIS BEFORE YOU START

You need the rehabilitation plan you built on **Friday 5 March**, the day your calendar calls **Designing a rehabilitation plan**, for your assigned patient. If you cannot find it, ask for a copy of your submission before you begin. The entire task is revising that plan, and there is nothing here you can do without it.

What you are doing

You will run your own plan through the review it would get in a clinic, change two things, and write a claim, evidence and reasoning paragraph defending why the revised plan gets your patient to a goal they actually stated.

WHAT THIS ITEM COSTS YOU

HOW LONG	SITTINGS	WHAT YOU NEED FIRST	WHAT YOU HAND IN
90 min	Two	Your Week 7 rehabilitation plan and your patient's record with their stated goals.	A revised plan card with two changes marked and dated, plus one CER paragraph. Hand both in together as one document.

The clinical idea behind this

In clinical practice this is called peer review or case consultation, and its whole purpose is to catch a safety problem before it reaches a patient. A plan that has been through review and changed is stronger than one that was never questioned. Nobody in a clinic treats a revision as a mark against the person who wrote the first

version, and the record keeps both versions on purpose so anyone reading it later can see what was known and when.

THE FOUR MEASURES THAT MAKE REHAB PROGRESS EVIDENCE RATHER THAN OPINION

- **Range of motion**, measured in degrees with a goniometer. The most objective single number in musculoskeletal rehab.
- **Pain**, on a 0 to 10 scale. Subjective by design, and still useful because it is the same scale each visit and the trend is what you read.
- **Functional task completion.** Can the patient do the specific thing they said they wanted to do. Stairs, a grip, a full overhead reach.
- **Strength testing.** Graded resistance, compared against the uninjured side where there is one.

Your CER has to cite at least one of these. A plan defended without a measurement is a preference.

Session one. Review your own plan

1. **Re-read your patient's record and copy out their stated goal, word for word.** Not your summary of it. The goal in their words is what the plan has to reach.

   Done when: The goal is written at the top of your page in the patient's own phrasing.

2. **Run the safety pass.** Go through your plan one exercise at a time and ask of each: does this load a structure that is not healed yet at this stage of recovery. Mark every one you are unsure about.

   Done when: Every exercise in your plan has been checked and marked, not just the ones you remembered.

3. **Run the feasibility pass.** For each exercise ask: can this patient actually do this, at this intensity, with the equipment and the time they have. Mark the ones that fail.

   Done when: You have at least one item marked, because a first-draft plan always has one.

4. **Write down the two changes you will make.** One from the safety pass and one from the feasibility pass. Say what the problem was, not only what you changed it to.

   Done when: Two changes named, each with the problem it fixes.

Session two. Revise and defend

1. **Rewrite the plan card with both changes in it.** Mark each changed line clearly and date it, the way a clinical record is amended. Do not erase the original. A record that hides what it used to say is worse than one with a correction on it.

   Done when: A reader can see what changed, what it changed from, and when.

2. **Add a checkpoint to each changed item.** A checkpoint is a measurement and a number: what you will measure, and what value tells you it is working. Use one of the four measures above.

   Done when: Each changed item has a named measure and a target value, not just 'reassess later'.

3. **Write the CER.** Claim: your revised plan will get this patient to their stated goal. Evidence: the specific checkpoints and measures you added, and what the record says about the patient's current status. Reasoning: connect the intervention to the goal through the anatomy. Say which structure the exercise loads and why that matters for that particular goal.

   Done when: Your reasoning names a structure and a movement, and your evidence contains at least one number with a unit.

4. **Add the honest limit.** One sentence naming what could still go wrong with your revised plan, or what you would need to know that the record does not tell you.

   Done when: You have named a real gap, not a token one.

THE DIFFERENCE REASONING MAKES

Both sentences describe the same change. Only one of them tells a reader why it was the right change for this patient.

> **Reasoning that is really a restatement:** I lowered the resistance because the original was too hard, which will help the patient recover better.
>
> **Reasoning that connects intervention to goal through anatomy:** I lowered the resistance on the knee extension because at four weeks the repair is still in the bony callus stage and loading it at the original resistance risks the site rather than the muscle. The patient's stated goal is climbing the stairs at home unassisted, which needs eccentric quadriceps control more than peak strength, so the revised plan builds controlled lowering first and adds resistance once range of motion passes 110 degrees.

Where people get stuck

My original plan was fine. I cannot find anything to change.

Then you have not run the two passes properly. Take the single hardest exercise in your plan and ask what would happen if the patient did it on their worst day, tired, alone, without you watching. Something in there needs a change.

I do not have my Week 7 plan.

Ask for a copy of your submission before you start. This item cannot be done from scratch, because the skill being assessed is revision and there is nothing to revise.

My checkpoint says 'check if the patient feels better'.

That is not a checkpoint. A checkpoint is a measure and a number: range of motion above 110 degrees, pain at or below 3 out of 10, four stairs without the handrail. Pick one of the four measures and put a value on it.

The reasoning section keeps turning into more evidence.

That happens to everyone. Evidence is what you observed or added. Reasoning is why that evidence supports the claim. If your reasoning sentence has no because in it, or nothing anatomical, it is probably still evidence.

Words this item uses

Range of motion (ROM)

How far a joint moves, in degrees, measured with a goniometer. The most objective number in this kind of rehab.

Goniometer

The hinged protractor used to measure joint angle.

Pain scale (VAS)

A 0 to 10 self-reported scale. Subjective, and useful because the trend across visits is comparable.

Functional task

A specific real thing the patient wants to do again. It is the goal the plan is aimed at.

Peer review

Colleagues checking a plan before it reaches a patient. It is a safety mechanism, not a judgement of the author.

Checkpoint

A named measure plus a target value, set in advance, that tells you whether the plan is working.

Bony callus

The hard stage of fracture healing, after the soft callus and before remodelling. Strong enough to hold, not yet strong enough for full load.

Eccentric contraction

A muscle producing force while lengthening, such as the quadriceps controlling the descent of a step. Often the harder half of a movement to rebuild.

How to submit

- **Where it goes.** The same place as everything else. Your class form on the portal, or handed to Mr. Mendoza in person. Extra credit does not need a different route.
- **What to hand in.** Your written pages. Photographs of handwritten pages are fine. A photograph you cannot read is not.
- **Put your name and period on every page and in every photograph filename.** Unlabelled work cannot be credited, and it is the most common way points get lost.
- **When.** Any day after the pack opens, up to the last week of the semester. There is no deadline inside that window and no penalty for going slowly.
- **Feedback.** You get it back with a note. If a piece is short of full credit you may fix the named thing and resubmit once.