Nonoperative Shoulder Dislocation and Instability Rehabilitation Protocol

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For anterior or posterior glenohumeral instability selected for nonoperative care. Confirm the direction of instability, associated injuries and referring clinician's restrictions. Advance according to pain, apprehension, motion and dynamic control. Reassess if the shoulder slips again or apprehension worsens.

Phase	Goals	Precautions / Restrictions	Treatment
Weeks 0–4	• Reduce pain and inflammation. • Protect the healing capsule. • Start pain-free ROM and limit atrophy.	• Use a sling or immobilizer for comfort as prescribed. Wean as directed. • Anterior instability — Avoid forced external rotation (ER) and horizontal abduction. • Posterior instability — Avoid excessive internal rotation (IR) and horizontal adduction.	• Begin gentle, pain-free flexion, scaption, ER and IR within protected ranges. Avoid stretching. • Use pendulums, shoulder isometrics and rhythmic stabilization. • For anterior instability, introduce modified closed-chain loading as tolerated. • Use ice and cardio without arm loading.
Weeks 4–8	• Restore full pain-free ROM and strength. • Restore joint mechanics, proprioception and dynamic control.	• Limit stress on healing structures. Progress through stable ranges without provoking apprehension.	• Advance ROM as tolerated. Start isotonic strengthening with an emphasis on ER and scapular control. • Progress neuromuscular drills from midrange toward end range. Add proprioceptive neuromuscular facilitation and open- and closed-chain work. • Add core training and cardio with arm use as tolerated. Ice as needed.
Weeks 8–12	• Build strength, endurance, power and neuromuscular control. • Prepare for higher-demand activity.	• Avoid excessive capsular stress. Use controlled, symptom-free motion to guide progression.	• Strengthen through full tolerated ROM. • Progress end-range stabilization, neuromuscular drills and endurance work. • Introduce plyometrics as control permits.
Weeks 12+	• Optimize strength, power and endurance. • Progress toward full work or sport demands.	• Use appropriate work-to-rest intervals. Check symptoms during activity, immediately after and 24 hours later. • Consider a stabilizing brace for contact sport when appropriate.	• Progress isotonic loading and functional drills with attention to form and control. • Resume usual lifting with clinician clearance.
Return to sport	• Review sport, competition level, season timing and ability to protect the shoulder. • Consider age, arm dominance, subluxation versus dislocation and bone loss.	• Clinician determines timing. • Full pain-free active and passive ROM. No pain or instability on provocative testing. • Mayo strength benchmark: ER:IR ratio >66% by isokinetic or handheld dynamometry.	• Select sport-specific tests such as throwing performance, Closed Kinetic Chain Upper Extremity Stability Test (CKCUEST), Upper Quarter Y-Balance or single-arm shot put. • Gradually advance sport-specific exposure before unrestricted play.