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1.0 Policy Statement

1.1 It is the policy of Cappagh National Orthopaedic Hospital to provide a patient focused physiotherapy service delivered by chartered physiotherapists and support staff working in a well-equipped environment.

1.2 It is the policy of Cappagh National Orthopaedic Hospital to provide health professionals and the public with the necessary advice and guidance on physiotherapy rehabilitation.

2.0 Purpose

2.1 The purpose of this guideline is to advise health professionals and patients on the physiotherapy rehabilitation of a patient undergoing Copeland humeral head resurfacing surgery.

3.0 Scope

3.1 This guideline applies to all staff involved in the care of a person undergoing Copeland humeral head resurfacing surgery, community staff involved in the pre and post-operative care of the patient, the patient and their family.

4.0 Health & Safety

4.1 There are health and safety risks involved in patient care, namely risk of physical injury to patient and staff, risk of infection.

4.2 Physiotherapists have the necessary qualifications and clinical experience to carry out this guideline and to supervise unqualified support staff.

4.3 They must be eligible for membership of their professional body, the Irish Society of Chartered Physiotherapists (ISCP).

4.4 They undertake mandatory manual handling, basic life support training, fire safety, infection prevention and control and risk management.

4.5 They complete a minimum of 100 hours continuing professional development every three years as required by the ISCP.

5.0 Responsibilities

5.1 It is the responsibility of physiotherapists to implement this guideline.
6.0 Definitions and Abbreviations
The Copeland Humeral Resurfacing Head, unlike a total shoulder implant, is designed to cap only the top of the humerus. The implant requires much less bone and cartilage removal, which makes it more conservative than total joints implants. The Copeland implant’s design and minimally invasive approach allow patients to potentially recover more quickly and with less pain. It is also potentially less complicated to replace should a future total shoulder replacement become necessary.

7.0 Guideline
7.1 Pre-Operative
7.1.1 Assessment as appropriate, to include shoulder, neck and scapular range of movement, muscle strength and general upper limb function.

7.2 Post-Operative
Review operation notes and post-operative physiotherapy instructions. Shoulder immobiliser may be fitted in theatre.

7.2.1 Day 1
7.2.1.1 Shoulder immobiliser removed for exercise – wean out of as comfort and control allows.

7.2.1.2 Teach axillary hygiene.

7.2.1.3 Teach postural awareness & shoulder girdle exercises.

7.2.1.4 Teach active elbow & finger movements.

7.2.1.5 Commence rehabilitation:
- Pendulum movements
- Active-assisted shoulder movements
- Avoid over activity and stretching of the subscapularis muscle for the first 2-3 weeks
- Ensure the patient has a follow up, out patient physiotherapy appointment arranged
7.2.2 Week 1-3
7.2.2.1 Progress active assisted flexion in supine to sitting position as soon as the patient is able. Progress to active when possible.

7.2.2.2 Progress to active-assisted abduction (maintain shoulder internal rotation) and external rotation (to neutral).

7.2.2.3 Begin isometric strengthening of all muscle groups (except internal rotation).

7.2.2.4 Commence hydrotherapy where available.

7.2.3 Week 3-6
7.2.3.1 Encourage the patient to actively move into all ranges with attention to gentle self-stretching at end of range.

7.2.3.2 Add isometric internal rotation.

7.2.3.3 Commence isometric theraband strengthening exercises (except internal rotation).

7.2.4 Week 6
7.2.4.1 Progress strengthening.

7.2.4.2 Continue to regularly stretch the joint to end of its available range.

7.2.4.3 Patient progression and outcomes will depend on the condition of the joint and soft tissues preoperatively. A better outcome is expected with patients whose joint is replaced for primary OA. Improvement continues for 18 months to 2 years and where possible the patient should not be discharged or should continue exercising until their maximum potential has been reached. The protocol outlined applies to patients with an intact rotator cuff. If a rotator cuff repair has additionally been carried out, the strengthening programme for cuff repair should be adhered to.
7.3 Return to Functional Activities

7.3.1 These are approximate and may differ depending upon each patient’s individual achievements. However, they should be seen as the earliest that these activities may commence.

**Driving:** After 4 weeks

**Swimming:** Breaststroke 6 weeks
Freestyle 3 months

**Golf:** 3 months

**Lifting:** Light lifting after 3 weeks.
Heavier items after 6 months

**Return to work:** Dependant upon the patient’s occupation. Those with sedentary jobs may return at 6 weeks. Manual workers or those whose occupations demand excessive shoulder use should be guided by the surgeon

8.0 Related Documents
Individual Physio tools exercise sheets

9.0 Appendices
N/A

10.0 References