# Copeland Surface Replacement Arthroplasty
(Hannan Mullett)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policy Statement</td>
</tr>
<tr>
<td>2.0</td>
<td>Purpose</td>
</tr>
<tr>
<td>3.0</td>
<td>Scope</td>
</tr>
<tr>
<td>4.0</td>
<td>Health &amp; Safety</td>
</tr>
<tr>
<td>5.0</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>6.0</td>
<td>Definitions and Abbreviations</td>
</tr>
<tr>
<td>7.0</td>
<td>Guideline</td>
</tr>
<tr>
<td>7.1</td>
<td>Pre-Operative</td>
</tr>
<tr>
<td>7.2</td>
<td>Post-Operative</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Day 1</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Day 2 – Day 5 (Discharge)</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Discharge (Day 5) to 3 Weeks</td>
</tr>
<tr>
<td>7.2.4</td>
<td>3 Weeks - 6 Weeks</td>
</tr>
<tr>
<td>7.2.5</td>
<td>6 Weeks</td>
</tr>
<tr>
<td>7.2.6</td>
<td>Return to functional activities</td>
</tr>
<tr>
<td>8.0</td>
<td>Related Documents</td>
</tr>
<tr>
<td>9.0</td>
<td>Appendices</td>
</tr>
<tr>
<td>10.0</td>
<td>References</td>
</tr>
</tbody>
</table>

---

**Document Approvals**

<table>
<thead>
<tr>
<th>Written by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire Falvey (Clinical Quality Manager)</td>
<td>May 2012</td>
</tr>
<tr>
<td>Lorraine Faughnan (Physiotherapist)</td>
<td>12/06/12</td>
</tr>
<tr>
<td>Anne Coyle (Physiotherapist)</td>
<td>16/07/12</td>
</tr>
<tr>
<td>Jill Long MISCP (Physiotherapy Manager)</td>
<td>01/06/12</td>
</tr>
<tr>
<td>Siobhán Coughlan (Clinical Quality Manager)</td>
<td>07/01/13</td>
</tr>
</tbody>
</table>

---

*This is a controlled document and is intended to be viewed via Q-Pulse therefore printed hardcopies expire within 24 hours from 16:17:41, 25/01/2013*
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 surface replacement arthroplasty surgery.

3.0 Scope
   3.1 This guideline applies to all staff involved in the care of a person undergoing Copeland surface replacement arthroplasty 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.
   
   5.5 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

6.1 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.

6.2 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.

6.3 This operative procedure is performed in cases of severe osteoarthritis or rheumatoid arthritis where pain is the predominant feature.

6.4 The hemi arthroplasty is the usual method of choice. Early mobilisation is encouraged. As Subscapularis is released and reattached to the anatomical neck of humerus at the end of the procedure, there should be no resisted internal rotation for the first three weeks and care should be taken with the range of external rotation.

7.0 Guideline

7.1 Pre-Operative
7.1.1 Patient assessment.
7.1.2 Patient’s constant score recorded.
7.1.3 Information given.

7.2 Post-Operative
7.2.1 Day 1
7.2.1.1 Mastersling with body belt fitted in theatre.
7.2.1.2 Cryocuff to reduce inflammation.
7.2.1.3 Finger, wrist and radio ulnar movements.
7.2.1.4 Active elbow flexion and extension.
7.2.1.5 Shoulder girdle exercises and postural awareness
7.2.2 Day 2 – Day 5 (Discharge)
7.2.2.1 Body belt removed.
7.2.2.2 Axillary hygiene taught.
7.2.2.3 Continue using cryocuff.
7.2.2.4 Exercises continue as above.
7.2.2.5 Hand gripping exercise.
7.2.2.6 Pendular exercises.
7.2.2.7 Passive flexion/extension in scapular plane in supine.
7.2.2.8 Continue with shoulder girdle exercises, postural awareness and include scapular setting.

7.2.3 Discharge (Day 5) to 3 Weeks
7.2.3.1 Remove sling when comfortable.
7.2.3.2 Pendular exercises continued.
7.2.3.3 Isometric strengthening exercises of all muscle groups (except IR).
7.2.3.4 Begin passive abduction (maintain shoulder in IR).
7.2.3.5 Begin passive external rotation to neutral only.
7.2.3.6 Begin active assisted flexion in supine and progress to sitting position as soon as the patient is able. Progress to active when possible.
7.2.3.7 Encourage relaxation and breathing control.
7.2.3.8 Hydrotherapy may begin if available.
7.2.4 3 Weeks - 6 Weeks
7.2.4.1 Encourage the patient to actively move into all ranges. Gentle assisted stretching exercise to increase range - do not force inner range ER.

7.2.4.2 Add isometric IR - Submaximally and only if pain free.

7.2.4.3 Commence isometric theraband exercises - resistance dependant on individual N.B. Take care with IR.

7.2.4.4 Progress to isotonic strengthening.

7.2.4.5 Encourage proprioceptive exercises-weight and non weight bearing.

7.2.5 6 Weeks
7.2.5.1 Encourage the patient to actively move into all ranges. Gentle assisted stretching exercise to increase range - do not force inner range ER.

7.2.5.2 Progress strengthening and include anterior deltoid exercises.

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

7.2.5.4 Can begin breaststroke if pain and range of movement allows.

7.2.5.5 How well the patient progresses and the outcome 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.

7.2.5.6 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 the repair should be adhered to.
7.2.6 Return to functional activities

7.2.6.1 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 can begin at 3 weeks. Avoid lifting heavy items for 6 months.

Return to work - Dependent 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 Physiotools exercise sheets

9.0 Appendices
N/A

10.0 References