Post Op Care Plan
The RNOH Shoulder Physiotherapy Service follows this care plan prior to discharge.

**Procedures:** Capsular Release/Manipulation under Anesthetic (MUA) Subacromial Decompression (SAD/ASAD)

**Goals:**
1. To educate the patient on post operative instructions and expected outcomes following surgical procedure.
2. To demonstrate application/removal of sling/brace as well as education on resting positions within post-operative restrictions.
3. To assess shoulder post operative ROM and to provide exercises/stretches within the post-op guidelines/restrictions.
4. To teach and ensure that the patient and/or carers are competent with the post operative exercise programme and can maintain the program post discharge.
5. To ensure all patients requiring further physiotherapy are given a copy of their outpatient referral prior to discharge and are aware that they can contact the Shoulder Service if local services fail to provide a timely appointment.

**NOTE:**

A. Patients who are having difficulty or are considered to be at high risk of losing ROM (Pain/Psychological state/Pre-op condition/existing pathology) should be considered for a delayed discharge and an URGENT referral to local outpatient and/or community services (if appropriate) must be provided.
B. Capsular release patients should achieve 90% of sedated ROM prior to discharge from hospital. Some patients may also require a roller towel regime to be continued post discharge.

**Initial Rehabilitation Phase One discharge - 6 weeks**

**Goals:**
1. Ensure Wound/Tissue Healing
2. Encourage effective pain control
3. Maintain/Increase Passive/Active Assisted ROM as documented on patient specific referral.
   (Note: Patients who have had a MUA/capsular release should achieve 90% of sedated shoulder ROM prior to discharge from hospital)
4. Initiate early isometric cuff and scapular control
5. Wean out of Sling as documented on patient specific referral (normally 1-3 weeks maximum)

**Restrictions:**
1. No hand behind back
2. No unsupported active elevation above shoulder height
3. Exercise should remain relatively pain-free

**Education:** Patient education on anatomy of shoulder complex, post-op restrictions, progression of short/long term goals in conjunction with guidelines,
postural advice/retraining, advise on functional activities (light waist-level, driving when comfortable, and return to work within early guidelines).

**Treatment options:**

- Ice and resting positions
- Stick exercises for passive and active assisted stretches
- Waist level isometric cuff control (patient must be in a supported position)
- Scapular setting and postural control
- Capsular stretches and manual joint mobilizations (mainly after 2 weeks)
- MUA/Capsular release patients may be required to use a roller towel regime at home to maintain ROM (will be arranged pre-discharge if appropriate)
- Encourage hand/wrist/elbow ROM ex’s to avoid secondary stiffness

**Milestones to progress to Phase Two:**
1. Adequate pain control
2. Adequate scapula control
3. ASAD - 90° passive flexion in neutral rotation
4. MUA/ACR - achieving at least 90% of PROM documented at inpatient discharge
5. Achieved time specific individual goals if specified on individual referral.

**Failure to meet milestones:**
1. Refer to ‘Failure to progress’ table
2. Delay progression to next phase of rehabilitation
3. Refer to/discuss with Shoulder and Elbow Unit

**Late Rehabilitation Phase Three: Weeks 6-24**

**Goals:**
1. To restore full active range of movement (patient specific).
2. To progress cuff control through range **to the exclusion** of deltoid and without inappropriate muscle patterning (Pecs, Lat, Traps, etc).
3. To develop power and endurance of appropriate muscle groups (patient specific) and relate to functional tasks.
4. Ensure appropriate scapulo/humeral rhythm.

**Restrictions:**
1. Where possible minimize exercises that may exacerbate pain.
2. Ensure the rotator cuff is functioning well at a low level and the humeral head is “snuggling” into the glenoid (i.e. subtle caudal movement is seen of humeral head on initiation of isometric abduction) and the patient is no longer hitching the shoulder before progressing to active exercises above shoulder level.

**Education:**
Patient education around pacing of activity, exercise caution with previously aggravating activities, ongoing postural education, Normal movement with functional activities and realistic expectations.

**Treatment options:**
Build up rotator cuff control through range to the exclusion of deltoid, then with deltoid supported and then finally with deltoid unsupported.
Use a closed and open chain exercise programme.
Capsular stretches as required for anterior and posterior capsule

<table>
<thead>
<tr>
<th>Failure to Progress: If a patient is failing to progress, then consider the following: <strong>Possible Problem</strong></th>
<th>Action</th>
</tr>
</thead>
</table>
| Pain Inhibition | Adequate analgesia  
Maintain pain free exercises  
Return to passive stretches  
Slow rehab programme  
If severe night/resting pain then refer to Shoulder Unit |
| Poor Rotator Cuff Control | Ensure passive range is gained  
Isometrics through range  
Rotation dissociation through range with decreasing levels of support and increasing resistance  
Slow progression through theraband resistances (e.g. Yellow/white tend to bias cuff and green tend to incorporate deltoid) |
| Poor Scapular Control | Work on scapular setting through range without pec and/or lat overactivity.  
Consider prone lying to develop control/awareness |
| Poor Core Stability | Develop patient appropriate stability programme. |
| Secondary ‘frozen’ shoulder | Maintain passive ROM as able  
Use manual mobilizations |
| Unable to gain strength | May need to increase ROM first |
| Patient exercising too vigorously | Education on pacing, risks of flare-up scenario |
| Poor patient compliance with HEP | Set functional based goals |
| Return to ADL to soon | Reduce activity levels |
| Cervical/thoracic referred pain | Assess and treat |
| Altered neurodynamics | Assess and treat |