

Reverse Shoulder Arthroplasty

A reverse shoulder replacement, where the ball sits on the shoulder blade and the cup on the arm.

Kieran Hirpara 4.0



This protocol guides your recovery after reverse shoulder arthroplasty (reverse shoulder replacement) with Dr Kieran Hirpara at Mater Private Hospital Rockhampton. Each phase below opens with a plain-English explanation of what is happening and what matters most, followed by the structured protocol written **for your physiotherapist** – bring this page or its PDF to your first physiotherapy visit so your rehabilitation stays coordinated. Your physiotherapist may adjust the plan depending on how your recovery progresses.

If you have any concerns about your wound after surgery, get in touch with the rooms. It is often helpful to take a photo of the wound and email it for review.

What to expect

You will have a numb arm when you wake up, and the feeling should start to return after about 24 hours. There may be some numbness or weakness for up to a week.

When you wake up from your operation, you will be in a sling, with a big pad over your shoulder. This pad will be removed before discharge. Underneath will be a waterproof dressing covering a surgical glue strip, which can be left alone for 2 weeks. Your stitches are dissolvable and do not need removing, but there may be some tails of stitch at each end of the wound that can be cut flush with the skin after 2 weeks. You will be booked to see our nurse for a wound check 1–2 weeks after your surgery. If you are unable to attend the dressing check, you can remove your dressing yourself after 2 weeks.

Approximate timeframes for return to activities:

- **Driving** – 6 weeks
- **Swimming** – breaststroke: 8 weeks; freestyle: 12 weeks
- **Golf** – 3 months
- **Lifting** – light lifting can begin at 6 weeks; avoid lifting heavy items for 6 months
- **Work** – sedentary job: 6 weeks; manual job: guided by your surgeon

Wearing your sling

Your sling supports your shoulder for comfort while the early soreness settles. It is there to support the weight of the arm – it is **not** holding a repair in place. The rules are simple:

- Wear it for about **2 weeks** for comfort and support, then start weaning off it during the day. A brief spell in the sling at night is fine if it helps you settle, but it is optional.
- Take it off for showers and for your exercises, once you have been shown how.
- Resting at home, it can come off whenever you are comfortable: arm supported on a pillow while sitting.
- Use ice if the shoulder is swollen or sore, especially after exercise.

Your physiotherapist will help you put the sling on at first, and will teach you to manage it independently before you go home. Fitting it correctly matters – a loose sling does not support you properly:

1. Always ensure that when fitting the sling, your elbow is positioned in the corner of the sling and well supported.
2. The end of a well-fitted sling should rest comfortably at the knuckle of your little finger. If your hand extends too far out of the sling, it will not provide you with adequate support.
3. Your sling has two Velcro straps – one which attaches around your neck and one around your waist.
4. Once you have positioned your elbow and forearm correctly, use your non-operated arm to swing the upper strap around your neck to the front and attach it through the upper loop on the sling.
5. Use the same method to attach the lower strap around your waist, securing through the lower loop on the sling.

During your time in the sling, be conscious of your posture at all times and avoid allowing your shoulders to adopt a slumped position. To achieve a good postural position, try to keep your ears, shoulders and hips in line – maintaining good posture is important for your back and will help prevent stiffness in your shoulder joint. A rolled-up towel placed in the small of your back when sitting can serve as a friendly reminder.

Your first days in hospital

Before you go home, the hospital physiotherapists will start you on a simple set of exercises, shown below. It helps to understand three terms they will use. *Active* range of motion means movement you do yourself, without aid or help. *Active-assisted* range of motion means using your other arm (or an object, such as a cane) to help move the arm. *Passive* range of motion means the arm stays completely relaxed while your other arm – or someone else – does the work. From the start you can begin moving the shoulder with assistance from your other arm and, within comfort, gently under your own power – often easiest lying on your back so gravity helps. Let comfort be your guide and progress as it allows.

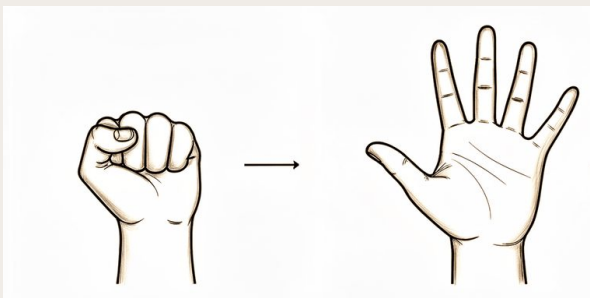
A few practical points for these first days:

- Use the sling for comfort. A brief spell in it at night is fine if it helps you settle, but it is optional.

- Use ice for pain relief if needed.
- When wearing your sling, relax your shoulder and let the sling take the weight of your arm.
- Take your painkillers before you do your exercises, and before your physiotherapy appointments.
- You are allowed to take your arm out of the sling for your exercises and showering.
- Wear the sling for comfort and support for about 2 weeks, then wean off it during the day.
- Unless you have chosen to arrange your own physiotherapy, an appointment has been made for you and is detailed in your discharge pack.
- If you have any problems, contact the office or let your physiotherapist know.

These are the exercises the hospital physiotherapists will start you on, continued at home as guided by your physiotherapist.

Your hospital exercises

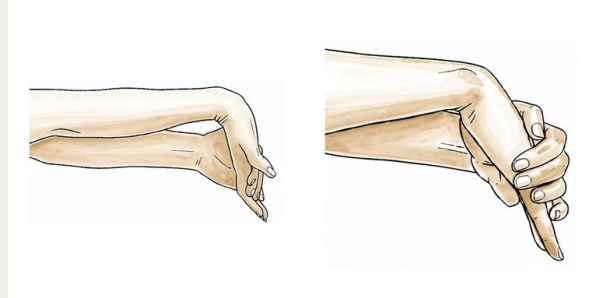


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Open and close hand

Keep your hand and fingers moving by opening and closing them, or by squeezing a soft ball.

10 times, 3 times per day

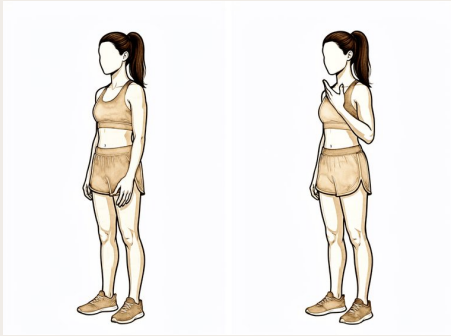


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Wrist movement

Keep your wrist moving by bending it forwards, backwards and side to side.

10 times, 3 times per day

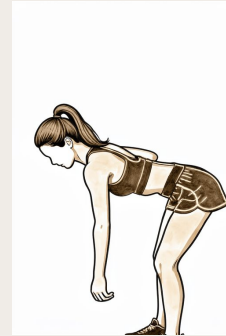


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Elbow

Bend and straighten your elbow.

10 times, 3 times per day

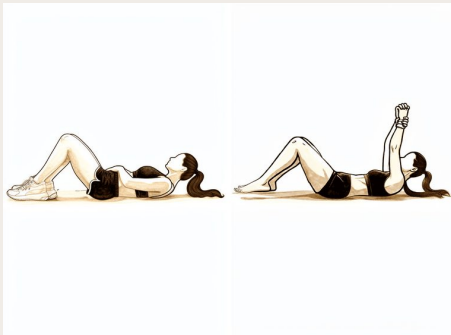


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Pendulums

This is a passive exercise. Lean forward and let your arm relax down. Use your body to move the arm gently either clockwise or anti-clockwise, along with forwards, backwards and side to side.

About 30 seconds each way, 3 times per day

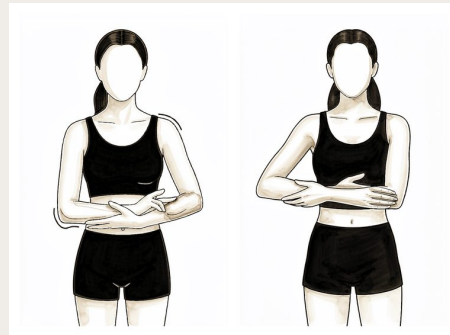


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Forward flexion

Sitting on a chair and leaning forward, cradle your operated arm with the other arm and gently move your arm upwards in front of you. Lower it back down with the assistance of your non-operated arm. You could also try lying on your back in bed and helping the arm upwards if you would prefer.

10 times, 3 times per day

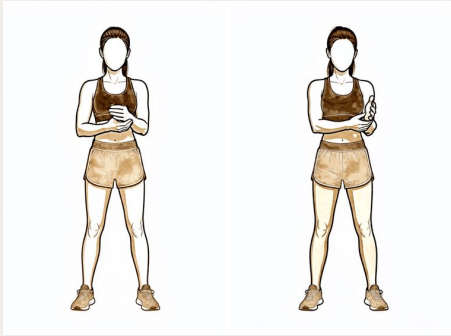


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Abduction

Sitting on a chair and leaning forward, cradle the arm again and help it out to the side (e.g. like rocking a baby).

10 times, 3 times per day

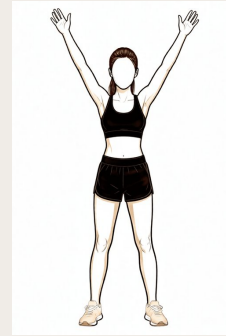


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External rotation

Sitting on a chair, only move your arm from where it would be in the sling to pointing straight in front of you. Don't go further outwards.

Gently, 10 times, 3 times per day



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Lower trapezius setting

Squeeze your shoulder blades downwards and together.

Hold 5 seconds, 5 times; repeat 3 times daily



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Upper trapezius stretch

Use your non-operated arm to bring your ear towards your shoulder, away from the operated side.

Hold 10 seconds, 3 times; repeat 3 times per day



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Levator scapulae stretch

Use your non-operated arm to bring your nose towards your nipple or armpit area.

Hold 10 seconds, 3 times; repeat 3 times per day

CQ HAND + UPPER LIMB

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Phase I – Protection (Weeks 0–3)



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Seated table slide

Sit at a table with your forearm resting on the surface. Let your hand slide forwards along the table as you lean gently in, letting the shoulder fold forwards without using the shoulder muscles, then slide back. Keep the movement relaxed and comfortable — the shoulder itself stays passive.

As guided by your physiotherapist

The first three weeks are about settling your new shoulder joint and easing it back into movement. You use the sling for comfort, manage swelling with ice and compression, and keep your elbow, wrist and hand moving. From the outset you also start gentle shoulder movement – assisted by your other arm and, within comfort, gently under your own power, often easiest lying on your back so gravity helps. Let comfort be your guide and do not force anything. The rules that matter most are about protecting the joint from slipping out of place: do not reach behind your back or rotate the arm inwards, do not lift anything, and do not push up through your hands. When lying on your back, keep a small pillow or rolled towel under your elbow so the shoulder does not stretch backwards.

For your physiotherapist:

Goals

- Protect component stability (avoid the dislocation position)
- Reduce swelling, minimise pain
- Maintain upper extremity (UE) range of motion (ROM) in elbow, hand and wrist
- Establish early shoulder active-assisted and active motion within comfort
- Minimise muscle inhibition
- Patient education

Sling

- Neutral rotation

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- For comfort and support; optional brief night use; wean off during the day from ~2 weeks

Management

- Swelling management: ice, compression
- Range of motion / mobility:
 - PROM: external rotation (ER) in the scapular plane to tolerance; flexion/scaption ≤ 120 degrees; abduction (ABD) ≤ 90 degrees; seated glenohumeral (GH) flexion table slide; pendulums; seated horizontal table slides
 - Active-assisted range of motion (AAROM): from the start – active-assisted shoulder flexion (begin supine/gravity-assisted), within the PROM limits above
 - Active range of motion (AROM): from the start – gentle active shoulder motion as tolerated within comfort; plus elbow, hand, wrist

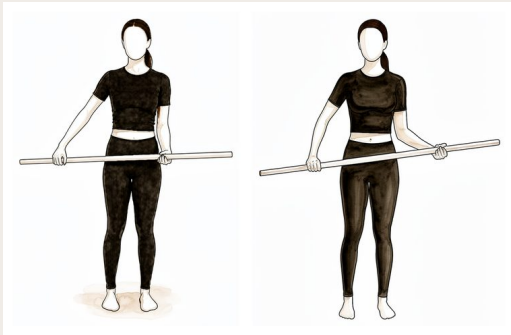
Precautions

- No shoulder PROM/AROM into internal rotation (IR)
- No reaching behind back, especially into internal rotation
- Avoid the combined extension + adduction + internal-rotation (dislocation) position
- No lifting of objects
- No supporting of body weight with hands
- Place small pillow/towel roll under elbow while lying on back to avoid shoulder hyperextension

Criteria to progress

- Gradual increase in shoulder PROM, AAROM and AROM within comfort
- 0 degrees shoulder PROM into IR
- Pain $< 4/10$
- No complications with Phase I

Phase II – Intermediate (Weeks 4–6)

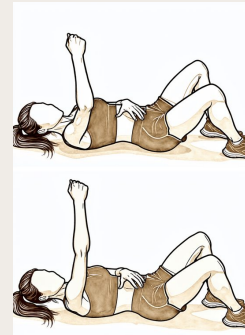


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Cane external rotation stretch

Lie on your back with your elbow by your side and bent to 90 degrees. Hold a cane or stick in both hands and use the non-operated arm to push the hand of the operated arm gently outwards, within comfort. Never force the movement.

As guided by your physiotherapist



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Supine punch

Lie on your back and hold the operated arm straight up towards the ceiling. Keeping the elbow straight, push the hand a little further towards the ceiling so the shoulder blade lifts off the bed, then lower back with control.

As guided by your physiotherapist

The shoulder now builds on the movement you began straight after surgery. Range of motion continues to increase, and the first activation and strengthening work for the shoulder-blade (periscapular) muscles and the deltoid begins around week 4. By this stage you should be out of the sling during the day; you may still use it briefly at night only if it adds comfort. The protective rules still apply: lift nothing heavier than a coffee cup, do not reach behind your back, do not push through your hands, and keep the pillow under your elbow when lying on your back.

For your physiotherapist:

Goals

- Continue to protect component stability (avoid the dislocation position)
- Reduce swelling, minimise pain
- Gradually increase shoulder PROM
- Progress shoulder AAROM/AROM
- Initiate periscapular muscle activation and strengthening (~week 4)
- Initiate deltoid activation and strengthening (~week 4; avoid shoulder extension when activating posterior deltoid)
- Patient education

Sling

- Discontinue daytime use (weaned off from ~2 weeks)

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- Optional brief night use only if it adds comfort

Management

- Continue with Phase I interventions
- Range of motion / mobility:
 - AAROM: active-assistive shoulder flexion, shoulder flexion with cane, cane external rotation stretch, washcloth press, seated shoulder elevation with cane
 - AROM: supine flexion, salutes, supine punch
- Strengthening:
 - Periscapular: scapular retraction, standing scapular setting, supported scapular setting, low row, inferior glide
 - Deltoid: isometrics in the scapular plane

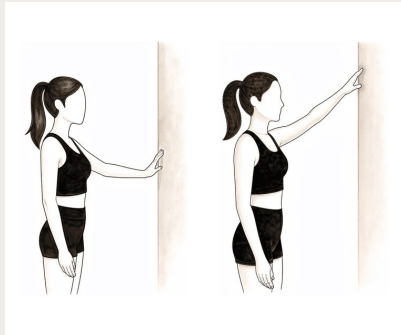
Precautions

- No reaching behind back, especially into internal rotation
- Avoid the combined extension + adduction + internal-rotation (dislocation) position through ~week 6
- No lifting of objects heavier than a coffee cup
- No supporting of body weight with hands
- Place small pillow/towel roll under elbow while lying on back to avoid shoulder hyperextension

Criteria to progress

- Gradual increase in shoulder PROM, AAROM, AROM
- 0 degrees shoulder PROM into IR
- Palpable muscle contraction felt in scapular musculature
- Pain < 4/10
- No complications with Phase II

Phase III – Intermediate, continued (Weeks 7–8)

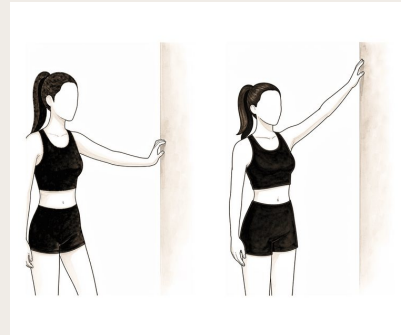


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Wall climbs

Stand facing a wall and walk the fingers of the operated arm up the wall as far as is comfortable, letting the wall assist the arm upwards. Walk the fingers back down with control – do not let the arm drop.

As guided by your physiotherapist



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Wall walk out to the side

Stand side-on to a wall with your fingertips resting on it. Walk your fingers up the wall out to the side, raising the arm as far as is comfortable, then walk them back down with control. The wall supports the arm as you regain movement out to the side.

As guided by your physiotherapist

The sling is well behind you by now. Movement progresses in all directions, including the first gentle passive internal rotation (rotating the arm inwards), and the strengthening work for the deltoid and shoulder-blade muscles steps up, along with the first motor-control (coordination) exercises. The limits that remain: nothing heavier than a coffee cup, no reaching behind your back beyond your pant pocket, no body weight through your hands, and avoid stretching the arm backwards behind your body.

For your physiotherapist:

Goals

- Minimise pain
- Gradually progress shoulder PROM; initiate shoulder PROM IR in the scapular plane
- Gradually progress shoulder AAROM
- Gradually progress shoulder AROM
- Progress deltoid strengthening
- Progress periscapular strengthening
- Initiate motor control exercise
- Patient education

Sling

- Discontinue

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Management

- Continue with Phase I & II interventions
- Range of motion / mobility:
 - PROM: full in all planes; gradual PROM IR in scapular plane \leq 50 degrees
 - AAROM: incline table slides, wall climbs, pulleys, seated shoulder elevation with cane with active lowering
 - AROM: seated scaption, seated flexion, supine forward elevation with elastic resistance to 90 degrees
- Strengthening:
 - Periscapular: row on a physioball, serratus punches
 - Deltoid: seated shoulder elevation with cane, seated shoulder elevation with cane with active lowering, ball roll on wall
- Motor control:
 - IR/ER in scaption plane and flexion 90–125 degrees (rhythmic stabilisation) in supine
- Stretching:
 - Sidelying horizontal adduction (ADD), triceps and lats

Precautions

- No reaching behind back beyond pant pocket
- No lifting of objects heavier than a coffee cup
- No supporting of body weight with hands
- Avoid shoulder hyperextension

Criteria to progress

- ROM goals (PROM and AROM expectations are individualised and dependent upon ROM measurements attained in the operating room post-operatively):
 - Elevation \leq 140 degrees
 - ER \leq 30 degrees in neutral
 - IR \leq 50 degrees in scapular plane, or back pocket
- Minimal to no substitution patterns with shoulder AROM
- Pain $<$ 4/10

Phase IV – Transitional (Weeks 9–11)

This phase is the bridge back to normal use of the arm. Passive movement should now be full in all planes, and the focus shifts to strengthening the deltoid and shoulder-blade muscles, building dynamic stability and

coordination, and gradually restoring strength and endurance – with a return to full functional activities. The one firm limit: no lifting of heavy objects (over 5 kg).

For your physiotherapist:

Goals

- Maintain pain-free ROM
- Progress periscapular strengthening
- Progress deltoid strengthening
- Progress motor control exercise
- Improve dynamic shoulder stability
- Gradually restore shoulder strength and endurance
- Return to full functional activities

Management

- Continue with Phase II–III interventions
- Range of motion / mobility:
 - PROM: full ROM in all planes
- Strengthening:
 - Periscapular: resistance band shoulder extension, resistance band seated rows, rowing, robbery, lawnmowers, tripod, pointer
 - Deltoid: gradually add resistance with deltoid exercise
- Motor control:
 - IR/ER and flexion 90–125 degrees (rhythmic stabilisation)
 - Quadruped alternating isometrics and ball stabilisation on wall
 - Field goals
 - Proprioceptive neuromuscular facilitation (PNF): D1 diagonal lifts, D2 diagonal lifts

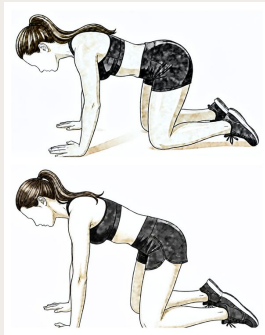
Precautions

- No lifting of heavy objects (> 5 kg)

Criteria to progress

- Performs all exercises demonstrating symmetric scapular mechanics
- Pain < 2/10

Phase V – Advanced strengthening (Weeks 12–16)

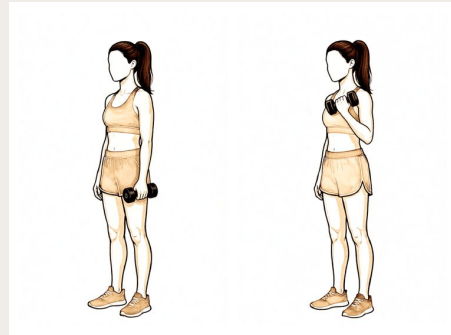


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Push-up plus on knees

From a push-up position on your knees with hands under the shoulders, keep the elbows straight and push the upper back towards the ceiling, letting the shoulder blades slide apart, then lower with control.

As guided by your physiotherapist



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Biceps curl

Holding a light weight with your palm facing up and your upper arm by your side, bend the elbow to bring the hand towards the shoulder, then lower with control. Keep the load light – heavy lifting (over 7 kg) is still off-limits in this phase.

As guided by your physiotherapist

The final phase conditions the shoulder for everyday life: keeping your movement pain-free while building the strength and endurance to use the arm confidently. If a rotator cuff repair was performed at the same time as your replacement, rotator cuff (RTC) strengthening starts now. The lifting limit rises, but heavy objects (over 7 kg) are still off-limits. The phase – and the protocol – finishes with clearance from your surgeon once all the milestones have been met.

For your physiotherapist:

Goals

- Maintain pain-free ROM
- Initiate rotator cuff (RTC) strengthening with a concomitant repair
- Improve shoulder strength and endurance
- Enhance functional use of upper extremity

Management

- Continue with Phase II–IV interventions
- Strengthening:
 - Periscapular: push-up plus on knees, “W” exercise, resistance band Ws, prone shoulder extension Is, dynamic hug, resistance band dynamic hug, resistance band forward punch, forward punch, T and Y, “T” exercise
 - Deltoid: continue gradually increasing resisted flexion and scaption in functional positions

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- Elbow: bicep curl, resistance band bicep curls, and triceps
- Rotator cuff: internal/external rotation isometrics, side-lying external rotation, standing external rotation with resistance band, standing internal rotation with resistance band, internal rotation, external rotation, sidelying ABD progressing to standing ABD
- Motor control:
 - Resistance band PNF pattern, PNF D1 diagonal lifts with resistance, diagonal-up, diagonal-down, wall slides with resistance band

Precautions

- No lifting of heavy objects (> 7 kg)

Criteria to progress

- Clearance from the surgeon, and ALL milestone criteria have been met
- Maintains pain-free PROM and AROM
- Performs all exercises demonstrating symmetric scapular mechanics
- QuickDASH and ASES patient-reported outcome measures

After your protocol

This protocol works alongside the practice's general recovery advice – see [managing post-operative pain](#) and [wound care](#). For the operation itself, see [reverse shoulder replacement](#).

The clinical evidence behind this protocol – the published rehabilitation trials, the reasoning for the sling and movement rules, and the research references – is set out in the accompanying evidence summary (available as a downloadable PDF).