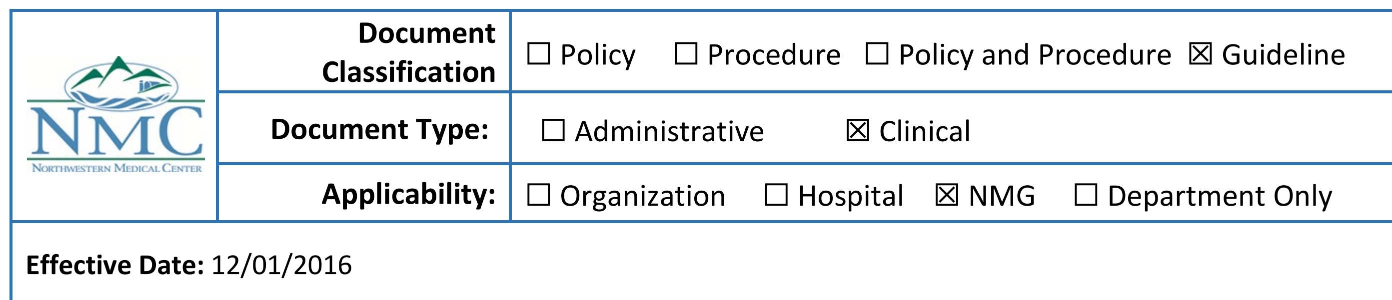
Total Hip Replacement Guidelines



	Document Classification	☐ Policy ☐ Procedure ☐ Policy and Procedure ☒ Guideline
	Document Type:	☐ Administrative ☒ Clinical
	Applicability:	☐ Organization ☐ Hospital ☒ NMG ☐ Department Only
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Purpose: To provide rehabilitation professionals with a defined process to be followed for all patients referred from Northwestern Orthopedics after the above procedure has been performed. This document is intended for use by all rehab professionals of the patients choice.

Target Users: Treatment will follow the defined guidelines below and be carried out by Physical Therapist, Occupational Therapist, Athletic Trainer and/or Physical Therapy Assistants. Variances will be communicated by the surgeon directly to the rehabilitation staff.

Definitions:

- AROM=Active Range of Motion
- AAROM= Active Assisted Range of Motion
- PROM= Passive Range of Motion
- ER= External Rotation
- IR= Internal Rotation
- PT= Physical Therapy
- OT-Occupational Therapy

Guidelines:

- No extremes of range of motion
- Patient to progress as tolerated
- Active stretching and ROM only
- All patient to attend at least one PT/OT visit for pre op education at Northwestern medical center- Reference Pre-Op Total Joint Replacement Outline

Home day of surgery

Not seen by physical therapist unless ordered by provider, will be seen by nursing staff

Goals: Edema and pain control education
Safe bed mobility, transfers & ambulation for discharge

Acute Care POD 0 – 3

Acute Care Physical Therapy begins on day of surgery or Post op day #1 (dependent on anesthesia and patients motor control). Frequency 2x/day

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Goals: Edema education
Safe bed mobility, transfers & ambulation for discharge
Patient education-HEP, frequent ambulation

Edema Control:
Ice/Elevation
Gait:
Expectation that patients are in a chair for breakfast and lunch
Ambulation with walker, cane or appropriate assistive device
Stair training performed on POD#1 or POD#2
Exercises:
(see attached copy at end of document)

Phase One (Post Op Day 5 to Post Op Week 5)
Outpatient physical therapy will begin. Aquatic PT can be considered around 4 weeks once the incision is fully healed with no scabs. Average frequency 2x/week variations pending objectives & functional status.

Goals: Control edema
Full knee and ankle AROM
Independent SLR and hip abduction in supine
Independent with ADL's individualized to patient

Edema Control (possible interventions may include):
Ice/Elevation
Kinesiotaping
ESTIM
Aquatic Therapy

Dressing change:
Aquacel AG removed, and the wound is cleansed with chloroprep. Then the dressing is re-applied at post op day 7-10 using good sterile technique Leave in place an additional 7-10 days, remove, and then leave open to air. If incision is still draining re-apply Aquacel AG and notify Orthopedic office. Patients may shower but patients should not soak in bathtub, hot tub or pool until incision is healed, at least 4 weeks after surgery. If the therapist or patient note any wound problems such as progressive redness, pain, swelling, heat, and in particular drainage or fever, call the orthopedic office at (802) 524-8915.

Gait:
- Independent with ambulation without an antalgic gait with or without assistive device.
- Independent negotiating stairs with or without an assistive device
- Initial focus on household environment, progressed to community environment.

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Exercises:

- Progression of ROM as tolerated.
- Bicycle and/or recumbent stepper.
- Progression of acute care home program (available at end of this document)
- Progressive Resisted Exercises, open/closed chain activities when swelling and pain are well controlled.
- Functional strengthening

<u>Phase Two Weeks 6+</u>

Frequency 1-2x/wk to 1x/every other week with tapered frequency until goals are met or patient plateaus. (Average time 4–12 weeks). Documentation to justify variations pending objectives & functional status. NMC Physical Therapy will recommend that patients utilize our 'open gym' for continuation of non-skilled exercises developed by the therapist.

Goals:

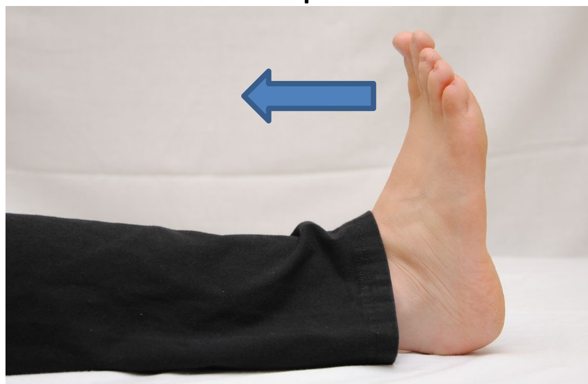
- Maximize AROM to equal to uninvolved.
- MMT > or = 4+/5 LE strength with patient specific functional activities
- Good proprioception with patient specific functional activities
- Independent gait without an assistive device (if safety allows) on uneven surfaces.
- Independent negotiation of stairs, reciprocal gait pattern without rail/cane if safe
- Independent driving if applicable

Exercises:

- Progressive Resistive Exercises
- Functional Strengthening
- Proprioceptive Training/Neuromuscular Re-education/Balance exercises

<u>Acute Care Exercise Program that patient is discharged with:</u>

Ankle Pumps



Isometric Buttock Strengthening

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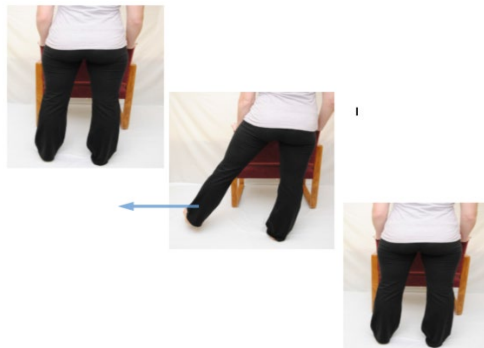
Quadricep Sets

Groin Stretch

Supine hip abduction

Standing hip abduction



Straight Leg Raise

Responsibilities:

Variances will be communicated by the surgeon directly to Rehabilitation Services.

References:

Clinical Orthopedic Rehabilitation a Team Approach
Fourth Edition Giangarra, Charles, Manske, Robert, Brotzman S. Brent copyright 2018

https://orthoinfo.aaos.org Last Reviewed February 2022

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Appendix(ces):
N/A

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