REHABILITATION AFTER REVERSE TOTAL SHOULDER REPLACEMENT

Reverse shoulder replacement recovery: sling about 4 weeks, passive movement from day one, driving about 6 weeks, no reaching behind the back for 12 weeks.

PATIENT NAME _____

DATE OF SURGERY _____

WHAT IS INSIDE

- What was done, and what to expect week by week
- Weight bearing, walking aids and precautions
- Your exercises, with a diagram and a dosage for each
- Warning signs, and exactly who to call
- Getting back to driving, work and sport
- A progress chart to fill in and bring to appointments

22 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 weeks. Then reviews at 3 months, 6 months and 12 months.

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This is a general guide. Your operation record and the instructions you are given always take precedence over anything written here. Last reviewed 27 October 2026.

This guide walks you through recovery after a reverse total shoulder replacement, week by week. What to do, what to expect, and when to call us. Two headlines. The new joint is stable from day one, so you start gentle movement straight away. But the muscle that now lifts your arm, the deltoid, takes months to learn its new job. Patience in the first six weeks buys you a better shoulder at six months.

A reverse replacement is a different design from a standard shoulder replacement. It is used when the rotator cuff tendons are torn beyond repair, after some fractures, and in some revision surgery. The goals are realistic and worth saying plainly. Most people get a shoulder that no longer hurts, that lifts the hand to head height and beyond, and that manages dressing, cooking, driving and a swim. Reaching far behind the back, and lifting heavy things with that arm, usually stay limited.

Every timeframe in this guide is typical, not a rule. Your shoulder, your health and your operation are your own. Dr Broadhead’s instructions for you always override the general figures here. If your operation record says a tendon was repaired, or a fracture was fixed at the same time, your limits may be stricter.

AT A GLANCE

USING THE ARM

No weight through the operated arm for 6 weeks. No lifting heavier than a cup of tea with that hand

SUPPORT

A sling for about 4 weeks, worn outdoors and at night; off for exercises, washing and sitting at home

SLING

Sling, not a brace

PRECAUTIONS

For 12 weeks, do not reach behind your back, and do not push up from a chair or bed through the operated arm

DRIVING

Typically about 6 weeks, once out of the sling and able to steer and brake without hesitation; later if the right arm is the operated one and you drive a manual

DESK WORK

Typically 2 to 3 weeks, one-handed at first

PHYSICAL WORK

Typically 3 to 4 months, and some heavy overhead jobs are not advised at all

SPORT & ACTIVITY

Walking from day one. Swimming and golf from about 3 months. Doubles tennis and bowls from about 4 to 6 months, if cleared

REVIEWS

Wound review at about 2 weeks. Clinical review with an X-ray at 6 weeks. Then reviews at 3 months, 6 months and 12 months

WHAT WAS DONE IN YOUR OPERATION

The shoulder is a ball and socket. In a normal shoulder the ball sits on the arm bone and the small socket is on the shoulder blade. In a reverse replacement, the surgeon swaps them. A metal half-ball is fixed to the shoulder blade. A cup on a stem sits in the arm bone and rests against it.

The swap moves the centre of the joint inward and downward. That gives the big deltoid muscle on the outside of the shoulder a better lever, so it can lift the arm on its own. The rotator cuff tendons, which a normal shoulder depends on, are no longer needed to lift the arm. That is why the design works in a shoulder where those tendons are torn or gone.

Through an incision at the front or the side of the shoulder, the worn ball was removed and the socket was prepared for the half-ball. The stem was fitted in the arm bone, with or without cement. The muscle at the front of the shoulder, the subscapularis, was either repaired back or left, depending on its condition. Your operation record says which.

THE IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

> **1. Stable from day one, strong from month three**
>
> The implant is fixed from the moment of surgery, which is why gentle movement starts straight away. What is not ready is the deltoid. It has never had to lift the arm alone. Strengthening it starts at about 12 weeks and continues for a year. Lifting the arm hard before then does not speed things up. It just strains the parts that are still healing.

> **2. The sling protects, it does not imprison**
>
> Wear the sling outdoors, in crowds, and in bed, for about four weeks. Take it off for your exercises, for washing, and when you are sitting safely at home with the arm supported on a pillow. Trial evidence shows that starting movement early, rather than keeping the arm strapped for six weeks, is safe and gives at least as good a result.

> **3. One position to respect**
>
> A reverse shoulder is most at risk when the arm is pulled back, turned inward and across the body at the same time. That is the position of reaching for a back pocket, tucking in a shirt, doing up a bra behind the back, or pushing up out of a chair with that hand. Avoid that combined position for 12 weeks. Reaching forward, out to the side and overhead is encouraged.

4. Passive first, then assisted, then active

For the first six weeks the other hand, a stick, a pulley or a table does the lifting. The operated arm goes along for the ride. From six weeks the operated arm starts to help. From about 12 weeks it lifts on its own and then against light resistance. Each step is earned by the one before.

5. Where the shoulder ends up

Most people get the arm to head height and above. Turning the forearm outward often improves little on average, so the hand works best in front of the body. Reaching behind the back often stays limited. In the largest study of recovery, most of the improvement had arrived by six months, with further gains to two years. Judge the operation at twelve months, not at six weeks.

USING THE ARM, AND THE SLING

WEIGHT BEARING

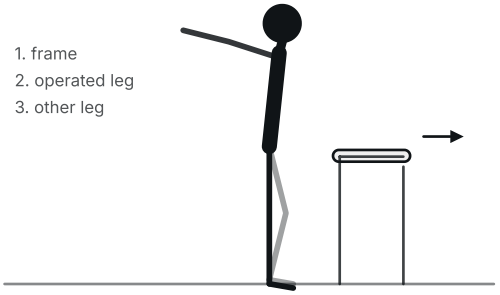
NO WEIGHT THROUGH THE OPERATED ARM FOR 6 WEEKS; LIGHT LOADS FROM 6 TO 12 WEEKS; STRENGTHENING FROM 12 WEEKS

For the first six weeks, the operated hand may hold a cup, a phone or a piece of toast. It may not carry a kettle, a bag or a grandchild, and it must not take your weight when you get out of a chair or bed. The implant is fixed, but the soft tissues and the bone around it are healing, and the deltoid is not yet ready to be loaded.

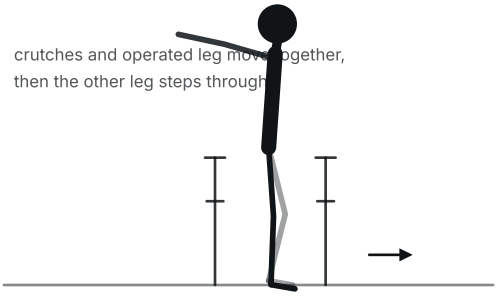
From six to twelve weeks, light use: a plate, a light shopping bag held close to the body, a saucepan with two hands. Still no pushing up through the arm and nothing heavy overhead.

From twelve weeks, strengthening begins and the limits are lifted step by step. The long-term advice is to avoid repeated heavy lifting and heavy overhead work with the operated arm. A sensible lifetime guide is nothing heavier than a few kilograms repeatedly with that arm, and nothing heavy at arm’s length.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Sling on, outdoors and at night	Weeks 0 to 4	Comfort; the arm supported when not exercising
Sling off indoors, on for crowds and travel	Weeks 2 to 4	Pain settling; confident the arm will not be knocked
No sling	From about week 4	Comfortable with the arm by your side; reviewed at the rooms or by your physiotherapist



Frame first, then the operated leg, then the other leg



Crutches and operated leg together, then step through

REVERSE SHOULDER PRECAUTIONS

TWELVE WEEKS

A reverse shoulder dislocates in a different direction from a normal shoulder. The at-risk position is the arm pulled back behind the body, turned inward, and brought across the midline, all at once. Those movements combine when you reach behind your back or push up out of a chair with that hand. The tissues that resist the joint levering out take about three months to heal and tighten. The rules below protect that one combined position. They do not stop you using the arm in front of you, out to the side, or overhead within your limits.

RULE	WHY	HOW TO MANAGE
Do not reach behind your back with the operated arm	Reaching for a back pocket, a bra strap or a belt pulls the arm back, turns it in and brings it across the body at once: the dislocating position	Front-fastening bras or fasten at the front then turn. Loose waistbands. Keep the wallet in a front pocket. Toileting hygiene with the other hand, or a long-handled aid.
Do not push up out of a chair, bed or bath through the operated arm	Pushing up levers the arm back and in with your body weight behind it	Push up through the legs and the other arm. Choose chairs with an arm on the good side. Sit on the edge of the bed and stand from there.
Do not lie on the operated shoulder	Your position is uncontrolled while you sleep, and the shoulder is tender	Sleep propped up on pillows, or on the other side with the operated arm on a pillow in front of you. Keep the sling on at night for the first four weeks.
Do not lift anything heavier than a cup with the operated hand for six weeks	The healing bone, the soft tissues and the untrained deltoid are not ready for load	Carry with the other arm. Slide things along the bench. Ask for help with shopping, washing baskets and pets.
Do not force the arm into rotation	If the front tendon was repaired, turning the forearm outward beyond the set limit	Your physiotherapist sets the limit from your operation record. Stop at it even when it feels easy.

RULE	WHY	HOW TO MANAGE
beyond your limit	can tear the repair in the first six weeks	

EVERYDAY SITUATIONS

Dressing. Operated arm in first, out last. Loose tops, front fastenings, slip-on shoes. Sit to put trousers on in the first weeks.

Washing. Shower once the dressing is waterproof or has been reviewed. Let the arm hang or rest it on a rail. Wash under the operated arm by leaning forward and letting it swing free, never by lifting it behind you.

Toileting. Use the other hand. A long-handled wiping aid helps in the first weeks if the operated side is your usual hand.

Eating. The operated hand may hold a fork and a cup from the start, with the elbow supported on the table. Cut food with the other hand.

Getting in and out of a car. Sit first, then swing the legs in. Do not pull the door shut with the operated arm or hold the grab handle with it. Sit in the back seat on the opposite side if the seat belt crosses the operated shoulder uncomfortably.

Sleeping. Propped on pillows at about forty-five degrees, or in a recliner, for the first two to three weeks. Pillow under the elbow and forearm. Sling on at night for four weeks.

Pets, grandchildren, gardening. No leads, no lifting, no pulling weeds with that arm for six weeks. Light garden tasks from three months.

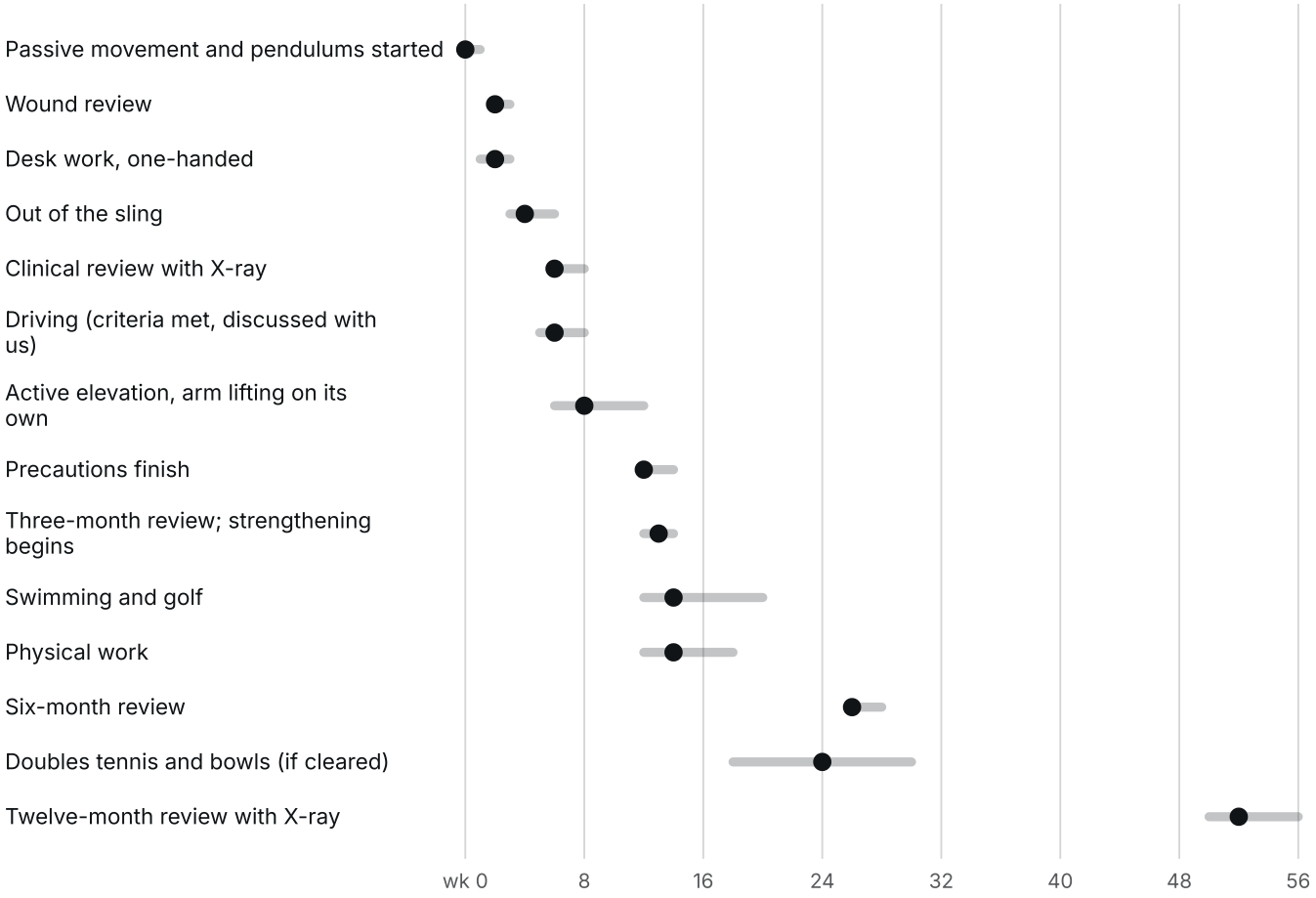
YOUR SLING

PERIOD	INSTRUCTION
Weeks 0 to 2	On at all times except exercises and washing. Loosen the waist strap when sitting with the arm supported on a pillow.
Weeks 2 to 4	Off when sitting safely at home with the arm supported. On outdoors, in crowds, when travelling, and in bed.
From week 4	Off, unless Dr Broadhead has asked you to keep it longer because a tendon or a fracture was repaired.

- The sling is fitted in hospital. It holds the elbow at a right angle with the forearm across the body and the hand a little higher than the elbow.

- Take the arm out of the sling at least four times a day to bend and straighten the elbow, and to let the arm hang for pendulums. A stiff elbow is avoidable.
- A small pillow or folded towel under the elbow when sitting takes the drag off the shoulder and eases the ache.
- Check the skin at the neck and wrist straps daily. Pad any rubbing.

YOUR RECOVERY TIMELINE



Bars show the earliest-to-latest normal window; the dot is typical. Your own dates are set with us, not by this chart.

THE PHASES, ONE BY ONE

You move to the next phase by meeting its exit criteria, not by the calendar. The week numbers are typical, nothing more.

PHASE 1: PROTECT, SETTLE, AND KEEP EVERYTHING ELSE MOVING

WEEKS 0 TO 2

Pain and swelling under control, the elbow, wrist and hand moving freely, and the first gentle passive movement of the shoulder.

GOALS: TICK THEM OFF

- [ ] Pain controlled on regular medication, with the arm supported
- [ ] Elbow fully straight and fully bent, wrist and fingers moving freely
- [ ] Pendulums and lying-down passive forward elevation done daily within your limit
- [ ] Wound dry, dressing intact, reviewed at about two weeks

DO THIS

- Elbow, wrist and hand pumps, ten of each, every hour you are awake.
- Pendulums three times a day: lean on the good arm, let the operated arm hang, small slow circles.
- Passive forward elevation lying down, the other hand lifting, to the limit you have been given, usually about 90 degrees in the first two weeks.
- Passive external rotation with a stick, lying down, elbow at your side, to the limit you have been given, often 20 to 30 degrees.
- Shoulder blade squeezes, sitting tall, ten holds of five seconds, twice a day.
- Ice for 15 to 20 minutes after exercises and before bed.
- Walk every day. Your legs are fine.

AVOID THIS

- Lifting the operated arm actively, on its own, away from your body.
- Reaching behind your back, or pushing up through the operated hand.
- Carrying anything heavier than a cup in that hand.
- Lying on the operated side.
- Driving.

READY FOR THE NEXT PHASE WHEN…

- Pain controlled, wound reviewed and settled
- Elbow, wrist and hand moving fully
- Passive forward elevation to about 90 degrees comfortably

PHASE 2: MORE PASSIVE RANGE, OUT OF THE SLING

WEEKS 2 TO 6

Grow the passive range towards 120 degrees of forward elevation, come out of the sling by about four weeks, and start using the hand for light daily tasks at waist height.

GOALS: TICK THEM OFF

- [ ] Sling off by about four weeks
- [ ] Passive forward elevation to about 120 degrees
- [ ] Passive external rotation to your set limit, usually 30 to 40 degrees
- [ ] Using the hand for eating, writing and light tasks with the elbow supported

DO THIS

- Continue pendulums, passive forward elevation and stick external rotation, twice a day, moving a little further each week.
- Table slides: sitting at a table, slide the hand forward on a cloth and lean in, so the arm rises without lifting it.
- Shoulder blade squeezes, and gentle neck and upper back movement, to keep the rest of the shoulder girdle loose.
- Use the hand at waist height: eating, writing, a keyboard, folding light washing.
- Keep walking daily. A stationary bike is fine from two weeks if you can balance without the arm.

AVOID THIS

- Lifting the arm on its own against gravity. Not yet.
- The combined behind-the-back position, and pushing up through the arm.
- Carrying bags, kettles or children with that arm.
- Stretching the external rotation past your set limit.

READY FOR THE NEXT PHASE WHEN…

- Out of the sling and comfortable with the arm by your side
- Passive forward elevation to about 120 degrees
- Six-week review done, with the X-ray checked

PHASE 3: THE ARM STARTS TO HELP

WEEKS 6 TO 12

Turn passive movement into active-assisted and then active movement, wake the deltoid up gently, and bring the hand into daily life above waist height.

GOALS: TICK THEM OFF

- [ ] Active-assisted forward elevation with a pulley or stick to your full passive range
- [ ] Active forward elevation, the arm lifting on its own, to at least 90 degrees by 12 weeks
- [ ] Gentle isometric strengthening started
- [ ] Washing the hair, reaching a cupboard at shoulder height, dressing without help

DO THIS

- Overhead pulley or stick-assisted elevation: the good arm does the work, the operated arm rides up, daily.
- Then active forward elevation lying down, where gravity helps, progressing to sitting and standing as it becomes easy.
- Isometric external rotation against a wall: gentle pressure, nothing moves, five-second holds.
- Light use of the hand above waist height: a cupboard at shoulder level, hair, a light pan.
- Walking, the stationary bike, and gentle swimming of the legs only, with the arm resting, if the wound is fully healed.

AVOID THIS

- Lifting anything heavier than a light shopping bag held close to the body.
- The behind-the-back position and pushing up through the arm: both still apply to 12 weeks.
- Resisted exercise with weights or bands. That is the next phase.
- Overhead work, painting, pruning, and anything repetitive above the shoulder.

READY FOR THE NEXT PHASE WHEN…

- Active forward elevation to about 90 degrees or more, without hitching the shoulder
- Able to dress, wash and prepare a simple meal independently
- Three-month review done

PHASE 4: BUILD THE DELTOID

MONTHS 3 TO 6

Strengthen the deltoid and the muscles around the shoulder blade, lift the precautions, and return to the activities that matter to you.

GOALS: TICK THEM OFF

- [ ] Active forward elevation to your full range, usually to head height and above
- [ ] Light resisted exercise, three times a week
- [ ] Driving, desk work and light physical work resumed
- [ ] Swimming and golf resumed, if cleared

DO THIS

- Forward raise with a light weight, no higher than the shoulder at first, slow up and slower down.
- Resistance-band external rotation and rowing, light band, high repetitions.
- Wall push-ups, from a standing lean, when cleared.
- Keep the pulley or stick stretch going until your range has stopped improving.
- Daily tasks without thinking about them: that is the aim.

AVOID THIS

- Heavy lifting at arm’s length, and heavy overhead work.
- Contact sport, and sports with falls.
- Rushing the weights. Light and often beats heavy and rarely.

READY FOR THE NEXT PHASE WHEN…

- Full active range for you, comfortable with daily use
- Six-month review done
- Activity goals agreed at review and progressing

PHASE 5: A SHOULDER FOR LIFE

MONTHS 6 TO 12 AND BEYOND

Keep the strength you have built, keep the range, and live within the long-term limits that protect the implant.

GOALS: TICK THEM OFF

- [ ] Twelve-month review done with an X-ray
- [ ] A home strengthening habit that continues
- [ ] Lifting limits understood and kept

DO THIS

- Strengthening two or three times a week, for life.
- Keep the arm reaching overhead daily. Range not used is range lost.
- Return to bowls, doubles tennis, cycling and gym work with the limits agreed at your review.

AVOID THIS

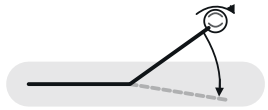
- Repeated heavy lifting with the operated arm, and heavy overhead loads.
- Falls onto the arm, where they can be avoided: care on ladders, wet floors and ice.
- Ignoring a new pain over the top of the shoulder that arrives weeks or months after surgery. Call.

READY FOR THE NEXT PHASE WHEN…

- Reviewed at twelve months, then as Dr Broadhead advises

YOUR EXERCISES

Little and often beats one heroic session. Each exercise lists what you should feel, sharp pain that lingers afterwards means ease off and, if it persists, call.



Ten of each, every hour you are awake, from day one

ELBOW, WRIST AND HAND PUMPS

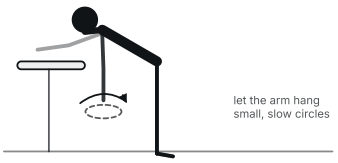
PHASE 1

Keep the elbow, wrist and hand from stiffening while the shoulder rests, and keep the blood moving.

10 of each, every hour you are awake

1. Take the arm out of the sling and support the upper arm on a pillow.
2. Bend the elbow fully and straighten it fully, ten times.
3. Circle the wrist slowly both ways, ten times.
4. Open the hand wide and squeeze a fist, ten times.

Feel: The shoulder stays still; only the elbow, wrist and hand move. A stiff elbow is the avoidable problem after shoulder surgery.



Lean on the good arm; let the other hang and swing

PENDULUM EXERCISE

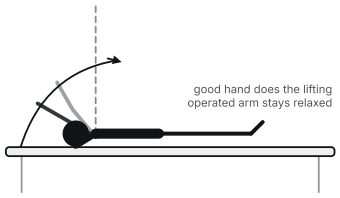
PHASE 1

Gentle movement of the new joint under gravity, with the muscles switched off. It eases pain and keeps the capsule from tightening.

1 to 2 minutes, 3 times daily

1. Lean forward with the good hand resting on a table or bench.
2. Let the operated arm hang straight down, relaxed.
3. Sway your body so the arm swings in small slow circles, then forward and back, then side to side.

Feel: The body moves the arm; the arm does not move itself. Keep the circles small. The size of a dinner plate is plenty.



The good hand lifts, within the range you were given

PASSIVE FORWARD ELEVATION, LYING DOWN

PHASE 1

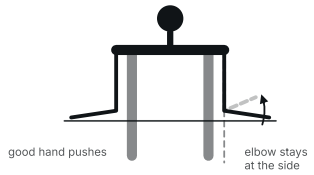
Restore the range of lifting the arm forward and overhead, with the other hand doing the work.

10 slow lifts, hold 5 seconds at the top, twice daily

1. Lie on your back. Hold the wrist of the operated arm with the good hand.
2. Keeping the operated arm relaxed, lift it up towards the ceiling and then towards the bed behind your head.
3. Stop at the limit you have been given. Hold, then lower slowly.

Feel: The operated arm is luggage. The good arm carries it. Lying down takes gravity out of it, which is why this is the first elevation exercise.

Harder: Raise the limit each week as your physiotherapist advises: about 90 degrees in weeks 0 to 2, towards 120 degrees by 6 weeks.



Push with the good hand, forearm out to your limit

EXTERNAL ROTATION WITH A STICK, LYING DOWN

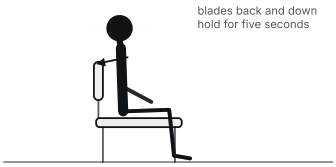
PHASE 1

Restore the turning-out range that lets you reach a seat belt, wash your face and eat.

10 slow pushes, hold 5 seconds, twice daily

1. Lie on your back. Keep both elbows bent to a right angle and tucked at your sides.
2. Hold a walking stick or broom handle in both hands.
3. Push with the good hand so the operated forearm swings outward, elbow staying at your side.
4. Stop at the limit you have been given. Hold, then return.

Feel: The elbow does not leave your side; if it does, the movement has gone to the wrong place. If the front tendon was repaired, this limit is strict in the first six weeks.



Sit tall, squeeze the blades back and down, hold

SHOULDER BLADE SQUEEZE

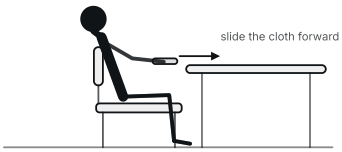
PHASE 1

Keep the muscles that steady the shoulder blade working. They are the platform the deltoid will lift from.

10 holds of 5 seconds, twice daily

1. Sit or stand tall with the arms relaxed, sling off if comfortable.
2. Draw both shoulder blades back and down towards each other.
3. Hold for five seconds, then relax.

Feel: Think of tucking the shoulder blades into your back pockets. No shrugging; the shoulders go back and down, not up.



Lean in as the hand slides; table carries the arm

TABLE SLIDE

PHASE 2

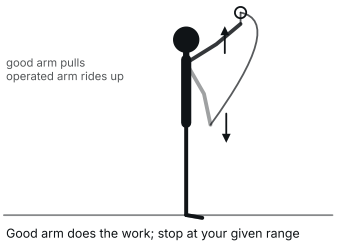
Forward elevation with the table carrying the weight of the arm: the bridge between passive and active.

10 slides, hold 5 seconds at the end, twice daily

1. Sit at a table with the operated hand resting on a cloth or a towel.
2. Slide the hand forward across the table while leaning your trunk in.
3. Hold at the far end, then slide back.

Feel: Let the table do the holding; the shoulder muscles stay quiet. Lean in from the hips, not by rounding the back.

Harder: Progress to sliding the hand up a wall, standing, once cleared.



Good arm does the work; stop at your given range

OVERHEAD PULLEY

PHASE 3

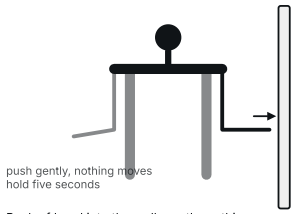
Take the arm to its full range overhead with the good arm doing the lifting, then let the operated arm share the work.

15 slow lifts, hold 5 seconds at the top, daily

1. Hang a pulley over a door, or use the one your physiotherapist provides.
2. Sit or stand facing or side-on to the door, a handle in each hand.
3. Pull down with the good arm so the operated arm rises overhead. Hold, then lower slowly.

Feel: The good arm does the work at first. Over the weeks, let the operated arm help. Stop at the range you have been given.

Harder: From about 8 weeks, start to lift the operated arm actively on the way up, using the pulley only to assist.



Back of hand into the wall, gently, nothing moves

ISOMETRIC EXTERNAL ROTATION AGAINST A WALL

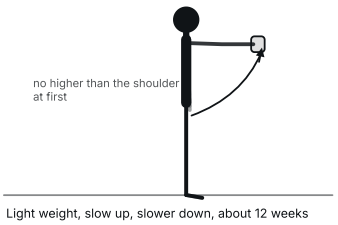
PHASE 3

Wake the rotating muscles up without moving the joint.

10 holds of 5 seconds, twice daily

1. Stand side-on to a wall with the operated elbow bent to a right angle and tucked at your side.
2. Press the back of the hand gently into the wall.
3. Hold five seconds. Nothing moves. Relax.

Feel: Gentle is the word: about a quarter of your strength. Turn to face the wall and press the palm in for the opposite muscles.



FORWARD RAISE WITH A LIGHT WEIGHT PHASE 4

Build the deltoid, which now lifts the arm on its own.

2 to 3 sets of 10, alternate days, from about 12 weeks

1. Stand tall holding a light weight, half a kilogram to start, or a tin of food.
2. Lift the arm forward with the elbow straight to shoulder height.
3. Lower slowly, taking twice as long on the way down.

Feel: No higher than the shoulder at first; add height as it becomes easy. If the shoulder hitches up towards the ear, the weight is too heavy.

Harder: Add half a kilogram every two weeks while it stays comfortable, up to about two kilograms. Then add a side raise.

SWELLING, ICE AND ELEVATION

WHAT IS NORMAL

- Bruising down the upper arm, sometimes to the elbow and the chest wall, in the first two weeks. It travels with gravity and is not a sign of a problem.
- A swollen hand and fingers in the first week, eased by the pumps and by keeping the hand above the elbow when you rest.
- Warmth and mild redness along the wound in the first weeks, settling.
- An ache at the end of the day, and after exercises, for some months.

ICE

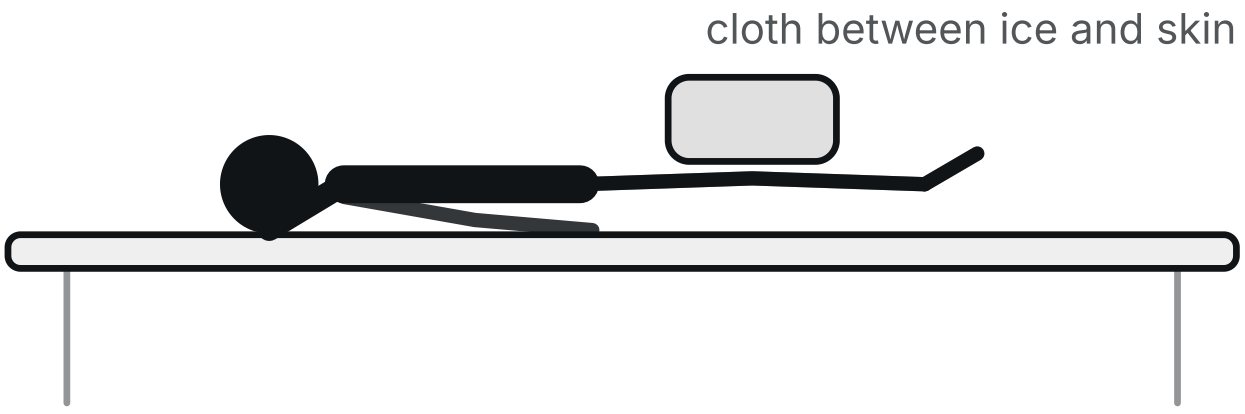
- Ice is safe, cheap and comfortable. It probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks. After that, use it as needed after activity and physiotherapy. It is most useful in the hour after exercise.
- Always put a thin cloth between the ice and your skin. Never sleep with ice on. Check with the rooms before you ice over numb skin or a fresh wound dressing.
- Stop and call the rooms if the skin turns white, blotchy or numb.
- An honest note about the evidence. The 2025 Cochrane review of icing after knee replacement (22 trials, 1,839 patients) found small improvements. Pain at 48 hours was

better by 1.6 points out of 10. There was about 8 degrees more bend at discharge, and less blood loss. All of this was low-certainty evidence. The reviewers concluded the benefits may be too small to justify routine use. Use ice because it is harmless and makes you more comfortable, not because it changes the final result.

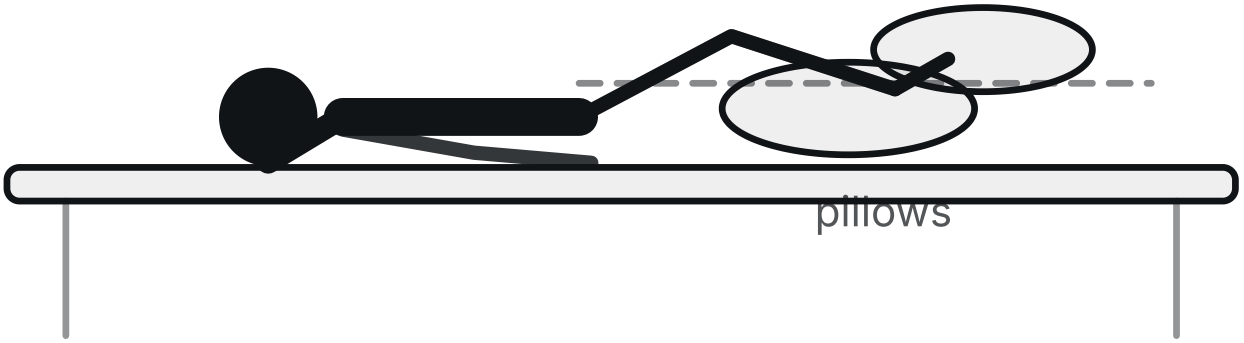
- There is no good evidence that expensive cold-compression machines work better than a bag of ice or a gel pack. The trials have never been analysed in a way that answers that question. Please do not spend money on one on our recommendation.

ELEVATION & COMPRESSION

- There is no leg to elevate here. What helps is support: the elbow and forearm on a pillow when sitting, so the shoulder is not dragged down by the weight of the arm.
- Swelling and bruising track down the arm towards the elbow and hand in the first week. The hand pumps keep it moving.
- Wear your graduated compression stocking or sleeve as advised. It helps control swelling.



15 to 20 minutes, 4 to 6 times daily



Foot above knee, knee above hip, lying flat

WOUND AND SCAR CARE

- Keep the dressing dry and in place until it is checked. Most modern waterproof dressings let you shower. Do not soak or scrub the wound, and do not put soap directly on it.
- No baths, spas, pools or ocean swimming until the wound is fully healed and has been checked. That usually means at least 2–3 weeks.
- Do not put creams, powders or antiseptics on the wound unless you have been told to.
- Clips or stitches are removed or checked at your first appointment.
- Tell the rooms if the dressing becomes soaked, loose or dirty.
- From about 3 weeks, once the wound is fully healed and dry, start massaging the scar. Use a plain moisturiser and firm circular pressure, for 2–3 minutes, twice a day. This softens the scar and makes the skin around it less sensitive.
- Silicone gel or sheets can improve the look of prominent scars.
- Protect the scar from the sun for 12 months. It burns easily and can darken permanently.
- Scars take a full 12–18 months to fade and flatten.

- Numb skin around and below the scar is normal, and often permanent. Small skin nerves have to be cut during surgery, and this cannot be avoided.

SLEEP AND POSITIONING

Sleep propped up on pillows at about forty-five degrees, or in a recliner, for the first two to three weeks. Lying flat drags on the shoulder; most people find it the sorest position early on.

Rest the operated arm on a pillow in front of you, with the elbow and forearm supported, so the shoulder does not hang.

Sling on at night for the first four weeks. It stops the arm rolling into the at-risk position while you sleep.

You may sleep on the non-operated side with the operated arm on a pillow in front. Not on the operated side until Dr Broadhead clears it, usually after about three months.

Disturbed sleep is common for the first few weeks. Ice before bed, timing pain relief for the night, and the pillow set-up above all help. In a pooled analysis, sleep had improved markedly by six months, with about one person in seven still troubled.

PAIN, MEDICATION AND WHAT TO EXPECT

Expect real pain for the first one to two weeks, needing regular pain relief. A nerve block done at the time of surgery often keeps the arm numb and comfortable for the first day; when it wears off, usually overnight, the pain arrives suddenly. Take the night-time dose before it does.

Take pain medication as prescribed and ahead of exercise sessions rather than chasing pain afterwards. Wean the strongest medications first as things settle,

usually within two to three weeks.

A blood thinner is not routinely needed after shoulder replacement. Clots are much less common than after hip and knee surgery. If you have a particular risk, you will be told.

Aches, stiffness and a sense of weakness continue for months and are normal. Pain that is increasing week on week is not, call the rooms.

Numbness in a patch of skin over the outer upper arm is common and usually improves. Nerve injury after a reverse replacement is uncommon, about one in a hundred, and nearly always recovers. Numbness or weakness in the hand is not expected: tell us.

Infection is the complication that matters most. It is uncommon, but a reverse shoulder carries a higher infection risk than other shoulder replacements, and the usual organism is a slow skin bacterium that can show up late. Treat any skin, dental or bladder infection promptly, and report any wound that leaks, reddens or opens.

PREVENTING BLOOD CLOTS

- Get up and move at least once an hour while you are awake.
- Do ankle pumps: 10 firm up-and-down pumps of the ankles, every waking hour for the first 2 weeks.
- Drink plenty of fluids.
- Take any prescribed blood thinner exactly as directed. Wear stockings as advised.
- Avoid long-haul flights for 6 weeks after joint replacement. Talk to the rooms before any earlier travel.

DRIVING: THE CRITERIA THAT ACTUALLY MATTER

You may drive when **all** of the following are true:

- You are off opioid painkillers and any other medicine that can make you drowsy.

- You can sit comfortably in the driver’s seat.
- You can do an emergency stop at full force, without hesitating and without pain.
- You are not using a walking aid in the car. You are not wearing a brace that limits the movement you need to work the pedals.
- You have practised the movements first in a parked car.

What the driving research does and doesn’t show

What the research actually measures is braking reaction time on a driving simulator. Those studies show braking gets back to its pre-surgery level at about 2 weeks after a right hip replacement, and about 4 weeks after a right knee replacement. Movement time is back to normal by 6 weeks. After knee arthroscopy (keyhole surgery), the simulator evidence is more cautious than common practice. In the one study that measured it directly, braking was still slower one week after surgery than before it. It had recovered by four weeks. A 2021 review of eight studies put the average return at about six weeks. Most people having a simple arthroscopy are driving well before that. That is why the criteria above matter more than the date. But these are averages. In one study, about one in three right-hip patients still could not meet an emergency-stop standard at six weeks. Treat the timeframes in this guide as targets to discuss with us, not as permissions.

No published study has compared automatic and manual cars. The logic is simple: a manual needs the left leg for the clutch. So in a manual, left-sided surgery is the one to be careful about. Advice about driving earlier after a left-leg operation in an automatic is clinical judgement, not trial evidence.

In Australia, your treating doctor’s advice is what counts. Under the Austroads "Assessing Fitness to Drive" standards, short-term impairment after surgery is a matter of clinical judgement. Commercial drivers are held to a higher standard. Driving while impaired may void your insurance, so

check your insurer’s position. Do not drive for at least 24 hours after any general anaesthetic or sedation.

GETTING BACK TO WHAT YOU DO

ACTIVITY	TYPICAL	WHEN IT’S RIGHT	NOTES
Walking for exercise	From the outset	Comfort; sling on outdoors for 4 weeks	Your legs are unaffected; walking is the core early exercise
Desk work	2 to 3 weeks	Pain controlled; able to work one-handed with the arm supported	Set the operated forearm on the desk or a pillow
Stationary cycling	From about 2 weeks	Able to balance without the arm	Upright bike; do not lean on the handlebars with the operated arm
Driving	About 6 weeks	Out of the sling; all the driving criteria below, discussed with us	Later for the operated right arm in a manual car; an automatic is easier. Your insurer expects the conversation to have happened
Swimming	About 3 months	Wound fully healed; active elevation to shoulder height	Breaststroke and freestyle gently; no butterfly
Golf	About 3 to 4 months	Cleared at the three-month review; chipping and putting first	Full swing from about 4 to 6 months
Physical work	3 to 4 months	Strength for the actual duties; cleared at review	Heavy overhead or repetitive lifting jobs may need permanent modification

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
Bowls, doubles tennis, cycling outdoors, gym weights	From about 4 to 6 months	Full range and comfortable strength; cleared at review	Low-impact, low-load, and no sudden jerks: fine for most. Keep gym loads light and repetitions high
Heavy lifting, contact sport, racquet singles, kayaking	Not recommended	Not applicable	The advice is about the implant and the deltoid: a lifetime limit of a few kilograms repeatedly with that arm, and nothing heavy overhead

Flying after joint replacement: an honest note

You will often hear "no flying for six weeks" after joint replacement. This is a convention, not a proven rule. A 2025 review found only limited data. It showed no demonstrated difference in clot risk between people who flew soon after a hip or knee replacement, most of them within the first week, and people who did not fly.

The six-week convention is based on practical realities rather than trial evidence. These include coping with airports and cramped seating, and being past the highest-risk clot window while still on prevention. Long-haul flights over four hours also carry a higher clot risk in their own right. Airline and travel-insurance rules vary, so check both. Some airlines impose their own restrictions.

Talk to the rooms first if you need to travel long-haul in the first six weeks. Clot prevention, an aisle seat, stockings and moving about on board can then be planned.

WARNING SIGNS: ACT, DON’T WATCH

None of these should be watched overnight to see how they go. Early treatment of a problem is simple; late treatment is not.

EMERGENCY: 000 Emergency department / call 000

- Sudden shortness of breath
- Chest pain
- Coughing blood, or feeling faint
- Sudden severe pain with the arm feeling out of place or unable to move, after a fall or a jolt: possible dislocation

GP TODAY See your GP today

- New, one-sided calf pain, tenderness or firmness
- Calf or whole-leg swelling out of proportion to the rest of your recovery

CALL THE ROOMS Call the rooms: same day

- Pain that is getting worse, not better, after the first week
- New redness spreading out from the wound
- Wound discharge, particularly cloudy, thick or smelly fluid, or wound edges opening
- Fever of 38°C or higher, or shaking chills, or feeling generally unwell
- New pain over the top or back of the shoulder blade, arriving weeks to months after surgery, worse with lifting the arm: possible stress fracture of the acromion
- Numbness or weakness in the hand, or a hand that is cold and pale
- A fall onto the operated arm, or a sudden change in what the arm can do

If you have a joint replacement, never "wait and see" with a wound problem. Call the rooms the same day. Early treatment of an infected joint replacement works far better than late treatment.

ARRANGING PHYSIOTHERAPY IN AUSTRALIA

- Most privately insured patients pay for private physiotherapy themselves or use extras cover. A GP Chronic Disease Management plan helps pay for only five allied-health visits per calendar year. That is not enough for a major reconstruction, so plan for this.
- If your care is covered by workers compensation or CTP insurance, you follow a plan approved by the insurer.
- Tele-rehabilitation (rehab by video call) and app-based home programmes are reasonable additions. But a sports knee reconstruction still needs in-person, measured strength testing at intervals.

COMMON QUESTIONS

How long do I wear the sling after a reverse shoulder replacement?

About four weeks: at all times for the first two weeks except exercises and washing, then off at home with the arm supported and on outdoors, in crowds and in bed. The trials are reassuring. Starting movement straight away rather than after six weeks gave the same results with no extra complications, a three-week sling gave the same result as no sling, and across 1,600 shoulders the dislocation rate was 1.4% whether movement started early or late. If a tendon or a fracture was repaired, Dr Broadhead may ask you to keep it longer.

When can I drive after a reverse shoulder replacement?

Typically about six weeks, once you are out of the sling, off strong painkillers, and can steer and brake without hesitation. It is later if the operated arm is your right and you drive a manual. Practise in a stationary car first, and confirm your timing with us. Your insurer expects that conversation to have happened.

What are the precautions after a reverse shoulder replacement?

One combined position for twelve weeks: do not reach behind your back, and do not push up out of a chair or bed through the operated arm. Those movements pull the arm back,

turn it in and bring it across the body at once, which is the direction a reverse shoulder can dislocate. Reaching forward, out to the side and overhead within your limits is encouraged.

How far will I be able to lift my arm?

Most people lift the arm to head height and above, which covers a cupboard, washing the hair and a wave. Turning the forearm outward often changes little on average, so plan on doing most things in front of you. Reaching behind the back often stays limited. Most of the gain arrives by six months, with more to two years.

Why can I not lift the arm myself in the first six weeks?

Because the muscle that now lifts it, the deltoid, has never done that job on its own, and the tissues around the new joint are healing. The other hand, a stick, a table or a pulley do the lifting first, so the range is restored without strain. The arm starts to help from six weeks and lifts on its own by about twelve.

How much can I lift with the operated arm, now and for good?

A cup for six weeks. A light shopping bag held close to the body from six to twelve weeks. Then more, step by step, as strength builds. For life, the sensible guide is nothing heavier than a few kilograms repeatedly with that arm and nothing heavy at arm’s length or overhead. The implant is designed for daily life, not for lifting.

Can I sleep on my side?

On the non-operated side, yes, with the operated arm on a pillow in front of you. Not on the operated side until it is cleared, usually at about three months. For the first two to three weeks most people sleep best propped up on pillows or in a recliner, with the sling on.

Do I need a blood thinner?

Not routinely. Clots are uncommon after shoulder replacement, under one in a hundred across 12,000 shoulders in a pooled analysis, far less common than after hip and knee surgery, and routine blood thinners are not recommended for most people. If you have a particular risk, or have had a clot before, you will be told and given one. Walking daily and the hand pumps are your clot prevention.

What is the new pain over the top of my shoulder months after surgery?

It needs a review rather than a wait. About two to four in a hundred people develop a stress fracture of the acromion or the spine of the shoulder blade after a reverse replacement, because the deltoid now pulls harder on that bone. Seven in ten happen without any injury, on average about a year after surgery, and osteoporosis and inflammatory arthritis raise the risk. It shows as new pain over the top or back of the shoulder, worse with lifting the arm. An X-ray or scan settles it, and most are treated with rest in a sling.

What is the risk of the shoulder dislocating?

Low, and highest in the first weeks. In a study of 6,600 reverse replacements, 1.6% of first-time replacements dislocated, half of them within the first seven weeks. The risk was higher after revision surgery and when the front tendon had not been repaired. The precautions in this guide, the sling at night for the first four weeks, and not pushing up through the arm are what you can do about it.

How long does a reverse shoulder replacement last?

Well. In the Australian registry, which records every joint replacement in the country, about 7 in 100 reverse replacements done for arthritis had needed further surgery at twelve years. In a long-term American series, 94% of patients said they would have the operation again ten years on. The reverse design is now about four in five of all shoulder replacements done in Australia.

Do I need a physiotherapist, or can I do this at home?

The exercises in this guide are the program, and the trials say a supervised program is not better than a well-taught home one: three randomised trials, including one of 222 shoulders, found home therapy matched formal physiotherapy. What matters is that you do the exercises every day and progress through the phases on the criteria. A physiotherapist is valuable at the start to teach the exercises and set your limits, and at the phase changes to check your range.

Will I set off the airport scanner, and do I need antibiotics at the dentist?

The implant often triggers a walk-through metal detector: tell the officer and you will be screened by hand. No card is needed. Antibiotics before dental work are not routinely recommended in Australia for a normally functioning joint replacement; keep your teeth healthy and tell your dentist about the implant.

THE EVIDENCE BEHIND THIS GUIDE 24 sourced statements

CLAIM	SOURCE
The reverse design moves the centre of rotation medially and downward so the deltoid can elevate the arm without a rotator cuff; a working deltoid and axillary nerve are prerequisites	Boileau et al., J Shoulder Elbow Surg 2005 (PMID 15726075); Hurley et al., rotator cuff consensus 2026 (PMID 42742935)
Immediate passive and active motion gave the same outcomes and complications as six weeks without motion (RCT, 86 shoulders)	Hagen et al., J Shoulder Elbow Surg 2020 (PMID 31924519)
Early active movement after reverse replacement was safe, with better flexion at three months (Australian RCT, 63 shoulders)	Edwards et al., Shoulder Elbow 2021 (PMID 34659491)
A three-week sling gave the same pain and function as no sling, with no complications (RCT, 64 patients)	Torrens et al., J Shoulder Elbow Surg 2025 (PMID 40089015)
Dislocation 1.4% with early and with delayed mobilisation across 1,606 shoulders	Alkhouri et al., systematic review 2026 (PMID 42267914)

CLAIM	SOURCE
Published protocols immobilise for a mean of 4.7 weeks, start passive motion in week 1, assisted motion at about 4 weeks and active motion at about 6 weeks; all include early deltoid isometrics	Obana et al., 2026 (PMID 42774556); Bullock et al., Int J Sports Phys Ther 2019 (PMID 31021690)
The at-risk position (arm extended, adducted and internally rotated) and the twelve-week precaution period are standard teaching, not a trial finding	Boudreau et al., J Orthop Sports Phys Ther 2007; the abstract carries no figures. Practice protocol, Dr Broadhead
Dislocation 1.6% after primary reverse replacement, median 7 weeks after surgery, higher after revision and without subscapularis repair (6,621 shoulders)	Lohre et al., ASES Complications of RSA Research Group, J Shoulder Elbow Surg 2024 (PMID 37379964)
Most improvement by 6 months, with further gains to 2 years	Simovitch et al., J Bone Joint Surg Am 2017 (PMID 29088034)
External rotation on average unchanged after reverse replacement; no deterioration in function between 5 and 20 years in pooled data	Ernstbrunner et al., systematic review 2019 (PMID 30674426)
Satisfaction 78% to 88%; at ten years 94% would have the operation again, implant survival 81% at 10 years in that series	Smith et al., J Shoulder Elbow Surg 2024 (PMID 38719073); Sheth et al., J Shoulder Elbow Surg 2022 (PMID 34656776)
Driving performance back to pre-operative level at 6 weeks after shoulder arthroplasty on a simulator; no excess crashes in a cohort of 406	Hasan et al., J Bone Joint Surg Am 2016 (PMID 27605691); DeBernardis et al., 2023 (PMID 36528223)
Return to sport 79% to 85% at a mean of 3.4 months; surgeons allow golf and swimming with experience after reverse replacement and advise against weightlifting	Davey et al., J Shoulder Elbow Surg 2021 (PMID 32858195); Singh et al., 2026 (PMID 40538058); Magnussen et al., 2011 (PMID 21051242); Golant et al., 2012 (PMID 21393018)
Return to work 64% at a mean of 2.3 months, lower for heavy work	Steinhaus et al., J Shoulder Elbow Surg 2019 (PMID 30885548)

CLAIM	SOURCE
Acromial and scapular spine stress fractures 3.8% (6,320 patients) and 2% pooled; 70% atraumatic; mean 11.3 months to diagnosis; osteoporosis and inflammatory arthritis double the risk	Moverman et al., J Bone Joint Surg Am 2024 (PMID 40305832); Elmenawi et al., 2026 (PMID 41602508); Abukar et al., 2026 (PMID 42774521)
Nerve injury 1.3% after reverse replacement, axillary nerve 0.6%; neurapraxias recover	North et al., J Shoulder Elbow Surg 2023 (PMID 36427756); LiBrizzi et al., 2019 (PMID 30984892)
Ten-year revision for infection 3.1% after reverse replacement in the Nordic registry; Cutibacterium acnes the commonest organism	Moeini et al., Bone Joint J 2019 (PMID 31154848); Nelson et al., J Shoulder Elbow Surg 2016 (PMID 27012542)
Symptomatic venous thromboembolism 0.81% after shoulder arthroplasty (12,566 shoulders); routine pharmacological prophylaxis not supported	Na et al., Int Orthop 2022 (PMID 35761099)
Sleep improves markedly by six months; 13% to 16% still troubled	Hali et al., Shoulder Elbow 2026 (PMID 42186454)
Reverse replacement is 80.9% of primary total shoulder replacements in Australia (2004 to 2022); 12-year cumulative revision 6.8% for osteoarthritis	Ingoe et al., JSES Int 2025 (PMID 40486774); Sandow et al., J Shoulder Elbow Surg 2022 (PMID 35577242), AOANJRR data
Home-based rehabilitation matches supervised physiotherapy after shoulder arthroplasty (three RCTs)	Rees et al., JSES Int 2025 (PMID 40959011); SHORT trial, Garrigues et al., 2026; Schick et al., 2023
A six-week home deltoid programme started a year after surgery still improved function	Wittmann et al., RCT 2026 (PMID 40849058)
Cryotherapy after shoulder surgery: a trend to less pain, inconsistent across trials; a cold-compression device was no better than ice	Karam et al., Orthop J Sports Med 2025 (PMID 40160286); Noyes and Denard, Am J Orthop 2018 (PMID 29979799)
Antibiotic prophylaxis before dental procedures is not routinely recommended in Australia;	Daly, Aust Prescr 2017; AAOS/AAHKS CPG 2024; Murgier et al., J Exp Orthop 2025 (PMID 41323538)

CLAIM	SOURCE
about 80% of joint replacements trigger a walk-through metal detector	

This guide is general information for patients of Dr Matthew Broadhead (Harbour Orthopaedics & Sports Medicine). It does not replace the specific advice given to you by Dr Broadhead, your physiotherapist or your hospital team.

Surgical findings vary, so your protocol may differ from what is written here. Your operation record and your surgeon's instructions always come first.

If in doubt, call the rooms on (02) 9052 1883. In an emergency, call 000.

Last reviewed: 2026-10-27 by Dr Matthew Broadhead, FRACS (Orth).

YOUR PROGRESS TRACKER

Fill this in once a week: it shows your trend at a glance and makes reviews far more useful. Bring it to every appointment.

Week	1	2	3	4	5	6	7	8	9	10	11	12
Exercises done (sessions)												
Walking distance / time												
Pain score (0–10)												
Knee bend (degrees)												
Swelling (less / same / more)												

QUESTIONS FOR DR BROADHEAD