Rehabilitative Care Alliance

Total Joint Replacement Quick Reference Guides

Updated May 2026

Quick Reference – Equitable and Culturally Appropriate Care

Summary of Best Practice Care	
	An approach of trust, respect and accommodation should be recognized as essential to the provision of equitable and culturally appropriate rehabilitative care.
	Rehabilitative care providers must ensure a safe, inclusive space to provide rehabilitative care with consideration for the patient's intersecting identities, health beliefs, practices and value.
	Rehabilitative care providers must use culturally appropriate language and a person-centred, history-taking approach, such as asking open-ended questions and ensuring privacy and confidentiality during interactions with all patients and care partners
	Rehabilitative care providers must learn about the health beliefs, practices and values of the cultural groups they serve and develop culturally responsive knowledge, skills and attitudes

***Page 14, 25, 33, 43, 57**

Quick Reference – Pre-Operative Care

Initiation	Screen pre-operatively to predict patients' post-operative and discharge needs, inform proactive discharge planning, identify potential post-op and/or discharge issues, including pain catastrophizing, and determine whether the patient would benefit from a preoperative in-home provider visit to assess the home environment. ***16-17**
Assessment	Assessment should include: baseline functional status, functional tolerance, discharge transition needs, equipment needs post-surgery, cognitive status, coping skills and social supports. The assessment informs the co-development of rehab goals with the patient and care partner(s).***17-18**
Summary of Best Practice Care	Patients & care partners are included in the circle of care and benefit from education through a number of media (e.g., videos, information booklets, education sessions). Opportunities are provided to ask questions and to access materials according to their needs.***14**
	Discuss with patients all aspects of their rehab care, including but not limited to: responsibility to participate in their recovery, expected length of stay, joint protection, pain management, assistive devices and equipment, preparing for post-surgical recovery and health promotion.***16**
	Tailored, patient-specific multi-modal prehabilitation, including range of motion, resistance, balance and endurance training, stretching, cognitive-behavioural interventions and functional training (e.g., ADLs and mobility), is recommended for both TKR &THR, particularly for older adults. Interventions may be individual (1:1) and individualized group-based.***16**
	Multimodal pain management education and prehabilitation is recommended, including but not limited to: sharing expected levels of pain; and pain management techniques, such as medications, cryotherapy and mindfulness meditation***22**
	Transition plans must be developed and agreed upon in partnership with the patient, their care partner/s and the health care team involved at each point of transition. A communication liaison (such as a discharge planner or navigator) must be designated as part of the circle of care.***22-23**
	Range of motion, strength, and gait speed should be measured, along with a generic and condition-specific patient reported, and performance outcome measures in order to establish a benchmark for post surgery progress ***23-24**

Quick Reference – Same-Day Discharge (SDD)

Summary of Best Practice Care
Focus protocols for SDD on safety for discharge, early mobilization and physiotherapy assessment, safe mobility and prophylactic therapies for pain and nausea. ***9-10**
Provide a preoperative education class to establish patient expectations for the day of surgery (SDD) and postoperatively, and give opportunity for questions to be addressed. Provide preoperative physiotherapy session to help transition home by giving instruction and demonstration for performing basic mobility tasks. ***15, 18**
Connect with patient via phone call/notification on the day before surgery to review arrival time and what the patient can anticipate on the day of surgery, and provide another opportunity to ask questions. ***18**
Start physiotherapy and mobilization, including ambulation and knee ROM exercises, 2-6 hours following surgery depending on the patient's motor control recovery following spinal anesthesia. All members of the interprofessional team work together to assist with early mobilization. ***27**
Provide full physiotherapy evaluation with weight-bearing as tolerated that includes range of motion, gait training with a walker or appropriate device, transfers in the bathroom, stair climbing and exercise. ***27**
Adjust shift schedules for physiotherapists to facilitate same day initial assessment, for example, after regular working hours. ***26**
Establish a plan regarding home exercises, outpatient physiotherapy and safety suggestions for home prior to discharge. ***30**
Communicate with the patient once home to provide opportunity to discuss issues directly with the care team. ***30**

Quick Reference – Rehabilitation in Acute Care/ICHSC[ɟ]

Initiation	A regulated rehabilitative care professional with knowledge and clinical experience in arthritis and TJR surgery should be responsible for the initial assessment prior to the first mobilization attempt. ***26**
Summary of Rehabilitative Care Best Practices	Structured multimodal postoperative education should address the knowledge gaps that patients have about the procedure, complications, postoperative precautions and self-care activities, lower perioperative anxiety, reduce postoperative pain and enhance functional recovery, and include the opportunity for patients and care partner(s) to ask questions and access materials according to their needs.***25**
	Initial treatment starting Post-op Day (POD) 0: early mobilization, range of motion exercises, foot and ankle pumping, deep breathing exercises, cryotherapy, rest and elevation.***26**
	Use multimodal pain management and education to maximize effect and outcomes. Assess pain using a standardized pain assessment instrument, e.g., The Numeric Pain Rating Scale (NPRS), Visual Analog Scale (VAS). Consider strategic use of PRN (as needed) pain medications (i.e., 30-45 minutes prior to assessment/treatment) to maximize participation and improve rehabilitative benefit.***29-30**
	Criteria for discharge: ambulates & transfers safely with mobility aid; stairs, as necessary; able to perform safe/supported ADLs; home exercise program provided; ongoing rehab plan in place. ***31**
	Transition plans must be developed and agreed upon in partnership with the patient, their care partner/s and the health care team involved at each point of transition. ***30**
	Plan is provided in writing to the patient & care partner, primary care team, specialists and rehab care providers and includes list of scheduled follow up rehab appointments. A communication liaison (such as a discharge planner or navigator) must be designated as part of the circle of care. ***30**
	Range of motion, strength, and gait speed should be measured, along with a generic and condition-specific patient reported and performance outcome measures.***31**

[ɟ]Integrated Community Health Services Centres

Quick Reference – Bedded Levels of Rehabilitation

Initiation **Duration** **Frequency**	Inpatient rehabilitation should not be the first choice for the typical patient with a primary unilateral or simultaneous bilateral elective total hip or knee replacement. Referral to inpatient rehab is guided by the RCA Referral Decision Tree. The timing, frequency and intensity of rehabilitative care services provided in a bedded level of care should be defined in consideration of functional tolerance, goals of the patient, RCA Rehab Care Standards for Bedded Levels of Care, and Quality Based Procedure Targets.***33, 35**
Summary of Rehabilitative Care Best Practices	Patients and care partners must be included as part of the circle of care and require accessible, actionable health information in order to manage their health and make fully informed decisions about their treatment and care ***33**
	Education on all of the following topics should be available and reviewed with patient and care partner(s) as appropriate: pain and swelling management (including post-hospital care), mobility, fall prevention, expected progress, caregiving/coaching training, safe activity resumption including return to sports, and driving, principles of healthy lifestyles and active living, provision of resources or referrals to external programs and sources of help, and TJR precautions, if applicable.***33-34**
	Assessment should include development of an individualized therapy plan (1:1 or group setting) and goal setting. ***35**
	Therapeutic interventions include but not limited to: exercises for active range of motion (AROM), strength and balance, functional training (e.g., gait, stairs, balance, transfers) including any applicable precautions, ADL/IADL assessment and training. ***35**
	Use multimodal pain management and education to maximize effect and outcomes. Assess pain using a standardized pain assessment instrument, e.g., The Numeric Pain Rating Scale (NPRS), VAS. ***39**
	Criteria for discharge: ambulate & transfers safely with mobility aid; stairs, as necessary, able to perform safe/supported ADLs; home exercise program provided; ongoing rehab plan in place.***40**
	Transition plans must be developed and agreed upon in partnership with the patient, their care partner/s and the health care team involved at each point of transition. Anticipate the expected date of discharge and discuss it with the patient and care partner(s). Plan is provided in writing to the patient & care partner, primary care team, specialists and community rehab care providers and includes list of scheduled follow up rehab appointments.***40**
	Range of motion, strength, and gait speed should be measured, along with a generic and condition-specific patient reported, and performance outcome measures. ***41**

Quick Reference – Rehabilitation in Outpatient/Community Clinics

Initiation	TKR: Rehab should begin within 7 days of discharge from acute care ***31** THR: Rehab should occur approximately 2-4 weeks post discharge ***32**
Duration/ Frequency	TKR: Treatment offered 2x/week for the first 6-7 weeks. Rehab should include intensive exercise (including home exercises) to achieve range of motion and function throughout the first 12 weeks post-surgery. THR: Average of 4 sessions (group or 1:1 format) for majority of patients with some patients requiring up to 8 sessions. Frequency depends on achievement of goals - typically 1x/week. Duration is based on the achievement of functional goals of independence or plateau in progression.***49**
Summary of Rehabilitative Care Best Practices	Rehabilitation to be provided or supervised by a regulated health care professional with knowledge and clinical experience in arthritis and TJR surgery.***29**
	Patients and care partners must be included in the circle of care communication and care planning. Multi-modal education should be provided to patients that can be tailored to their individual preferences and experiences. ***43**
	Education should include: pain and swelling management, mobility, fall prevention, expected progress, caregiving/coaching training, safe activity resumption including return to sports and driving, principles of healthy lifestyles and active living, provision of resources or referrals to external programs, and TJR precautions, if applicable. ***43-44**
	Therapeutic interventions include but not limited to: exercises for range of motion (ROM), strength and functional training. Both individual and group exercise programs can be beneficial, and the level of supervision should be matched to the patient's needs. ***45**
	Virtual rehab may be recommended with consideration for: slow recovery, difficulty assessing red flags, equipment barriers, lack of access or digital literacy. A hybrid approach may be advisable. Apps/wearable devices have shown many benefits: improved activity levels, optimized pain management, enhanced functional outcomes and accountability, and remote care monitoring.***52**
	Use multimodal pain management and education to maximize effect and outcomes. Assess pain using a standardized pain assessment instrument, e.g., The Numeric Pain Rating Scale (NPRS), Visual Analog Scale (VAS). ***53**
	Range of motion, strength, and gait speed should be measured, along with a generic and condition-specific patient reported, and performance outcome measures. ***55**

Quick Reference – In-Home Rehabilitation

Initiation	Rehab care provided by a PT and/or OT should begin within 7 days of discharge; earlier if patient is high risk. ***59**
Duration	**TKA:** Rehab should include intensive exercise to achieve range of motion and function throughout the first 12 weeks post-surgery. **THA:** The duration of rehab is dependent on patient needs. The typical maximum duration of in-home rehab is 12 weeks, if patient is unable to access outpatient rehab. Model of care encourages and empowers self-management. ***60-62**
Frequency	**TKA:** Frequency is more intense in the first few weeks (2-3 x/week) due to risk of contracture or loss of range of motion. THA: The typical number of visits is 1x/week, for the first few weeks, and then based on the progress of the patient thereafter.***60-62**
Summary of Rehabilitative Care Best Practices	The patient may require a short-term "Transition to Outpatient from Home" service to overcome physical barriers of their home setting (e.g., stairs) in order to attend rehabilitative care in outpatient/community clinic. Patients receiving in-home rehabilitation should be monitored for their progress and regularly reassessed to determine whether their functional goals can be met in an outpatient/community setting outside of the home. ***57**
	Patients and care partners must be included in the circle of care communication and care planning. Multi-modal education should be provided to patients that can be tailored to their individual preferences and experiences. ***57**
	Education should include but not limited to: pain and swelling management, mobility, fall prevention, expected progress, caregiving/coaching training, safe activity resumption, including return to sports, resume driving, principles of healthy lifestyles and active living, provision of resources or referrals to external programs, TJR precautions, if applicable. ***57-58**
	Assessment should include development of an individualized therapy plan (1:1 or group setting) and goal setting. ***59**
	Virtual rehab may be recommended with consideration for: slow recovery, difficulty assessing red flags, equipment barriers, lack of access or digital literacy. A hybrid approach may be advisable. Apps/wearable devices have shown many benefits: improved activity levels, optimized pain management, enhanced functional outcomes and accountability, and remote care monitoring.***64**
	Use multimodal pain management and education to maximize effect and outcomes. Assess pain using a standardized pain assessment instrument, e.g., The Numeric Pain Rating Scale (NPRS), Visual Analog Scale (VAS). ***65**
	Range of motion, strength, and gait speed should be measured, along with a generic and condition-specific patient reported, and performance outcome measure. ***67**