CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

REHABILITATION PROTOCOL

Subacromial Decompression — Rehabilitation Protocol

This protocol covers the rehabilitation after an isolated arthroscopic subacromial decompression (acromioplasty, with or without removal of the inflamed bursa) with Dr Kieran Hirpara at Mater Private Hospital Rockhampton. Bring this page or its PDF to your first physiotherapy visit so your rehabilitation stays coordinated. Your rehabilitation is progressed individually by your physiotherapist through the phases below, depending on how your shoulder progresses.

Important: subacromial decompression is often performed together with a rotator cuff repair. This protocol is for an isolated subacromial decompression. If your operation also included a rotator cuff repair, follow the rotator cuff repair protocol instead — the repaired tendon sets a slower pace.

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

Subacromial decompression makes more room for the rotator cuff tendons by shaving the under-surface of the acromion (the bony roof of the shoulder) and removing the inflamed bursa. Nothing is repaired that needs protecting, so early rehabilitation is about movement, not rest: the shoulder is safe to move from the first day, and moving it early is what keeps it from stiffening while it settles.

The sling you wake up with is for comfort only — it is not protecting anything. Leave it off as much as possible and wean out of it early: most people leave the sling off within the first few days, and published protocols expect it to be gone by two weeks at the latest. **Do not drive while you are wearing a sling.**

Your exercise program uses three kinds of movement, and your physiotherapist will guide which apply at each stage:

- **Active range of motion** — movement is allowed without aid or help.
- **Active-assisted range of motion** — using the other arm or an object to assist with moving the arm.
- **Passive range of motion** — completely relaxed, using the other arm or force to do 100% of the work.

The journey at a glance:

- **Phase I — Early movement** — roughly the first two weeks

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- **Phase II – Restoring your range and starting strength** – week 2–6
- **Phase III – Strengthening** – week 6–12
- **Phase IV – Return to full activity** – week 12 onwards

The shoulder is usually sore rather than fragile in the early weeks, and some people find it stays uncomfortable for up to six weeks. Published guidance suggests most people feel a clear improvement in pain by about three months, and symptoms can keep improving for up to a year. The week ranges below are typical rather than fixed – your physiotherapist will progress you on how your shoulder is moving, not on the calendar.

Phase I – Early movement (Week 0–2)

A nerve block is often used during the operation, so the arm can feel numb for some hours afterwards; start your painkillers before it wears off. In the first two weeks the aims are simple: settle the pain and swelling, and get the shoulder moving within comfort. Use ice regularly for pain relief. Start moving your hand, wrist and elbow straight away, add pendulum exercises and assisted arm movements as comfort allows, and use the arm for normal light daily activities such as washing, dressing and eating. Take your painkillers before your exercises and before physiotherapy appointments. This is keyhole surgery, usually through two or three small puncture wounds closed with adhesive strips – keep them dry until healed, which usually takes 10–14 days. People in desk-based jobs commonly return to work within the first two weeks; driving can resume once you are out of the sling and can control the car comfortably – including performing an emergency stop – which is typically somewhere between one and three weeks after surgery.

For your physiotherapist:

Goals

- Settle pain and swelling
- Re-establish non-painful range of motion (active-assisted progressing to active)
- Prevent muscular atrophy and begin re-establishing dynamic stability
- Independence with light activities of daily living

Management

- Cryotherapy regularly for pain and swelling; analgesia before exercises and sessions
- Elbow, wrist, hand, neck and thoracic range-of-motion exercises from day 1
- Pendulums; pulley or wand active-assisted elevation in the scapular plane; external and internal rotation starting at 30–45° of abduction
- Progress to active range of motion as comfort allows
- Scapular setting in sitting; postural awareness
- Submaximal isometrics (flexion, extension, abduction, external and internal rotation) and gentle rhythmic stabilisation

- From week 2: heat before exercise if helpful; progress rotation work towards 90° of abduction; external and internal rotation with elastic tubing, arm at the side

Precautions

- Work within comfortable ranges — do not force or overstretch; pain is the guide
- Sling for comfort only; wean within the first days and discard by two weeks
- No driving while wearing a sling
- No heavy lifting, no lifting overhead, no jerking movements
- Avoid pushing up from a chair or bed through the operated arm for the first six weeks — the acromion has been thinned and forceful loading should be avoided while it remodels

Criteria to progress

- Pain well controlled with simple analgesia
- Swelling settling and wounds healed or healing without concern
- Comfortable active-assisted movement, with active movement returning below shoulder height

Phase II — Restoring your range and starting strength (Week 2–6)

This phase is about getting the rest of your movement back and beginning to rebuild strength. Your exercises progress from assisted movements to moving the arm actively in all directions, with most published protocols expecting full or near-full range by about six to eight weeks. Strengthening starts gently — first without weight, then with elastic bands and very light weights for the rotator cuff and shoulder blade muscles. Many people find heat before exercise and ice afterwards helpful. Moderate work (light lifting below shoulder height) typically becomes possible during this phase, guided by your physiotherapist.

For your physiotherapist:

Goals

- Full, or near-full, active range of motion in all planes by around week 6–8
- Regain and improve rotator cuff and scapular strength
- Normalise scapulohumeral rhythm and neuromuscular control
- Continue to settle pain

Management

- Progress range of motion in all planes, including behind-the-back internal rotation with gentle posterior capsular stretching
- Glenohumeral joint mobilisation (inferior, posterior and anterior glides) as indicated

- Isotonic program beginning unweighted — shoulder elevation, prone rowing, prone horizontal abduction, prone extension to neutral, sidelying external rotation, abduction to 90° — adding light weight (around 0.5–1 kg) after a week of pain-free, well-controlled repetitions
- External and internal rotation with elastic tubing; progress towards rotation work in more elevated positions as comfort allows
- Scapular neuromuscular control and lower trapezius work; trunk, core and lower-limb conditioning
- Upper-limb endurance work; heat before and ice after sessions as preferred

Precautions

- Avoid loaded work in a painful impingement range — exercises may be hard, but should not reproduce the pre-operative pain
- Do not target supraspinatus or mid-deltoid loading until it is pain-free, and avoid it if it provokes resting or night pain
- Continue to avoid pushing up through the operated arm and heavy or overhead lifting until six weeks

Criteria to progress

- Full, non-painful range of motion with minimal tenderness
- Rotator cuff strength around 4/5 on manual testing, with good scapular control

Phase III — Strengthening (Week 6–12)

With your movement back, attention turns to strength, endurance and control. Resistance work progresses from bands to weights, and exercise becomes more dynamic — including, for people returning to sport, the start of controlled plyometric work and a graduated return to training. Swimming typically resumes from about six weeks (breaststroke first, freestyle when comfortable), and medium work — light lifting below shoulder height — is usually manageable from six weeks. An interval return-to-sport program commonly starts at weeks 10–12 when strength criteria are met.

For your physiotherapist:

Goals

- Improve strength, power and endurance of the shoulder complex
- Optimise neuromuscular control, proprioception and movement patterning (no shoulder hitching)
- Prepare for a graduated return to sport and heavier work

Management

- Progress the isotonic program: isometrics → elastic bands → weights; rotator cuff, deltoid and scapular stabilisers at 2–3 sets of 8–12 repetitions

- Introduce eccentrically resisted work, closed-chain exercises and rhythmic stabilisation; proprioceptive work including weight-bearing and four-point kneeling
- Plyometric activities — two-handed drills (chest pass, side-to-side throws) progressing to one-handed drills (wall dribbles, throwing drills) towards the end of the phase
- Begin an interval sports program at weeks 10–12 if criteria are met
- Continue core and conditioning work; cryotherapy as needed

Precautions

- Exercises should be difficult but essentially pain-free — back off any work that provokes resting or night pain
- Heavy lifting and sustained overhead loading wait until around three months

Criteria to progress

- Full, pain-free active range of motion (approximately equal to the other side)
- Strength approaching the other side (published criteria range from 70% to enter dynamic training, towards 90% for return to sport)
- No pain or tenderness with progressive loading

Phase IV — Return to full activity (Week 12 onwards)

The final phase is a graduated return to heavy work, overhead tasks and sport. Heavy or repetitive lifting and sustained work above shoulder height typically resume from about three months. Return to competitive sport — particularly overhead sport — is based on meeting criteria rather than the calendar: full pain-free movement, strength close to the other side and confidence with sport-specific drills. The shoulder commonly keeps improving well beyond this phase — published guidance describes improvement continuing for up to a year.

For your physiotherapist:

Goals

- Graduated return to heavy work, overhead activity and sport
- Maintain range of motion, strength and control in the long term

Management

- Continue the strengthening program, advancing gym- and sport-specific work as tolerated
- Continue the interval sports program with a staged return to throwing and other overhead sport
- Self-managed capsular stretches and maintenance exercises as needed

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Precautions

- Progression remains symptom-guided — if pain recurs, reduce load, restore comfortable movement and rebuild

Criteria to progress

- Full, non-painful range of motion
- Strength and functional testing satisfactory (around 90% of the other side in published return-to-sport criteria)
- Satisfactory clinical review

After your protocol

The phases above are adapted from published rehabilitation protocols and patient guidance for arthroscopic subacromial decompression — OrthoIndy, Sports Surgery New York, Gundersen Health System Sports Medicine, Twin Cities Orthopedics, Oxford University Hospitals NHS Foundation Trust and Royal Berkshire NHS Foundation Trust. The week ranges are typical rather than fixed, and your ongoing rehabilitation is guided individually by your physiotherapist, working with the practice, based on how your shoulder recovers. This page works alongside the practice's general recovery advice — see managing post-operative pain and wound care. For the operation itself and the condition it treats, see subacromial decompression.

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