

Occupational therapy for adults undergoing total hip replacement

Practice guideline

College of
Occupational
Therapists



Quick Reference Guide

The Quick Reference Guide provides a summary of the recommendations in the College of Occupational Therapists practice guideline ***Occupational therapy for adults undergoing total hip replacement*** (COT 2012). The guideline aims to provide an evidence-based resource for occupational therapists working within this speciality.

The overall grade of a recommendation is depicted in the guideline document with a numerical, then alphabetical grade to reflect the strength of the recommendation and quality of the evidence (e.g. 2C – conditional recommendation, low quality). Tables outlining the strength and quality grading categories are provided on page 5.

These evidence-based recommendations are not intended to be taken in isolation and must be considered in conjunction with the contextual information provided in the full guideline, together with the details on the strength and quality of the recommendations. The recommendations are intended to be used alongside clinical expertise and, as such, the occupational therapist is ultimately responsible for the interpretation of the evidence-based guideline in the context of their specific circumstances and service users.

Evidence overview

The majority of the 54 items of evidence from which the recommendations were developed were assessed as low or C grade (63%). 3.7% of the evidence was graded as high (A), 18.5% as moderate (B) and 14.8% as very low (D). Sixteen of the 25 recommendations are graded as strong.

Research priorities identified included the impact of relaxing hip precautions on rehabilitation outcomes and dislocation rates, standardised assessment and outcome measures for acute fast tracked rehabilitation, and the occupational therapy role in standardised care pathways.

Recommendations

Maximised functional independence		
1.	It is recommended that the occupational therapy assessment is comprehensive and considers factors which may affect individual needs, goals, recovery and rehabilitation, including co-morbidities, trauma history, personal circumstances, obesity and pre-operative function. (Johansson et al 2010, C; Lin and Kaplan 2004, C; Marks 2008, C; Naylor et al 2008, C; Ostendorf et al 2004, C; Vincent et al 2007, C; Wang et al 2010, C)	1 C
2.	It is recommended that goal setting is individualised, enhances realistic expectations of functional independence, and commences at pre-operative assessment. (Judge et al 2011, C; Mancuso et al 2003, C)	1 C

3. It is recommended that occupational therapists ensure that they provide clear communication and advice that is consistent with that of other members of the multidisciplinary team. <i>(Fielden et al 2003, C)</i>	1 C
4. It is recommended that depression and anxiety status are taken into account during pre-operative and post-operative intervention due to their potential for impact on recovery. <i>(Caracciolo and Giaquinto 2005, C; Nickinson et al 2009, C)</i>	1 C
5. It is recommended that cognitive status is taken into account during pre-operative and post-operative intervention due to its potential for impact on recovery. <i>(Wang and Emery 2002, C; Wong et al 2002, C)</i>	1 C
6. It is recommended that service users are fully involved in decisions about the equipment required to enable them to carry out daily living activities and to comply with any hip precautions in their home environment post-surgery. <i>(Thomas et al 2010, D)</i>	1 D
7. It is recommended that service users are given advice on effective pain management strategies, to decrease pre-operative pain experience and sleep disturbance, and enhance post-operative physical function. <i>(Berge et al 2004, B; Montin et al 2007, C; Parsons et al 2009, C)</i>	1 B
8. It is suggested that standardised assessment and outcome measures are used, where appropriate, to determine functional outcomes and occupational performance in rehabilitation settings, either inpatient or community based. <i>(Gillen et al 2007, C; Kiefer and Emery 2004, C; Oberg et al 2005, D)</i>	2 C

Reduced anxiety

9. It is recommended that the pre-operative assessment undertaken by the occupational therapist allows adequate time for individualised questions and discussion of expectations and anxieties. <i>(Fielden et al 2003, C; McDonald et al 2004, A; Montin et al 2007, C)</i>	1 A
10. It is suggested that occupational therapists offer support and advice to service users who may be anxious about an accelerated discharge home. <i>(Heine et al 2004, D; Hunt et al 2009, D; Montin et al 2007, C)</i>	2 C
11. It is recommended that pre-operative assessment and education is carried out in the most appropriate environment for the service user. For the majority of service users a clinic environment is appropriate, but where needs are complex, a home assessment should be an available option. <i>(Crowe and Henderson 2003, B; Drummond et al 2012, C; Orpen and Harris 2010, C; Rivard et al 2003, B)</i>	1 B

12. It is suggested that provision of equipment pre-operatively may facilitate familiarity and confidence in use. <i>(Fielden et al 2003, C; Orpen and Harris 2010, C)</i>	2 C
13. It is suggested that service users may value being treated by the same occupational therapist throughout the process, from pre-operative assessment/education to post-operative rehabilitation wherever possible. <i>(Spalding 2003, C)</i>	2 C
14. It is suggested that occupational therapists should contribute to standardised pre-operative education interventions, providing information, advice and demonstrations where relevant (e.g. of joint protection principles, equipment). <i>(Coudeyre et al 2007, B; Johansson et al 2007, B; Spalding 2003, C; Spalding 2004, C; Soever et al 2010, C)</i>	2 B

Resumption of roles

15. It is recommended that work roles are discussed at the earliest opportunity as part of a comprehensive assessment. <i>(Bohm 2010, C; Mobasheri et al 2006, D; Nunley et al 2011, C)</i>	1 C
16. It is suggested that for service users who are working, advice is provided relating to maintaining their work role pre-operatively, post-operative expectations and relevant information for employers. <i>(Bohm 2010, C; Mobasheri et al 2006, D; Nunley et al 2011, C; Parsons et al 2009, D)</i>	2 C
17. It is recommended that occupational therapists provide advice to facilitate service users to establish previous and new roles and relationships, and shift their focus from disability to ability. <i>(Grant et al 2009, C)</i>	1 C

Low readmission rates

18. It is recommended that occupational therapists consult with the surgical team regarding any specific precautions to be followed post-operatively. <i>(Hol et al 2010, B; Peak et al 2005, B; Restrepo et al 2011, B; Stewart and McMillan 2011, C; Ververeli et al 2009, B)</i>	1 B
19. It is recommended that occupational therapists advise service users, where protocol includes precautions, on appropriate position behaviours for those daily activities applicable to the individual's needs, ranging from getting in/out of a car to answering the telephone. <i>(Drummond et al 2012, C; Malik et al 2002, D; Peak et al 2005, B; Stewart and McMillan 2011, C; Ververeli et al 2009, B)</i>	1 B

20. It is suggested that due to the uncertainty surrounding the need for hip precautions, and the potential for an increase in satisfaction and early functional independence when hip precautions are relaxed or discontinued, occupational therapists engage in local discussion/review of the emerging evidence with their surgical and multidisciplinary teams. (Drummond et al 2012, C; O'Donnell et al 2006, D; Peak et al 2005, B; Restrepo et al 2011, B; Ververeli et al 2009, B)	2 B
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Decreased length of hospital stay	
21. It is recommended that occupational therapists optimise length of stay, with due reference to care pathways and enhanced recovery programme guidance. (Berend et al 2004, C; Bottros et al 2010, C; Brunenberg et al 2005, C; Husted et al 2008, C; Kim et al 2003, B)	1 B
22. It is recommended that the occupational therapist is involved in early multidisciplinary post-operative intervention for service users following hip replacement, providing either inpatient or home-based rehabilitation. (Iyengar et al 2007, C; Khan et al 2008, A; Siggeirsdottir et al 2005, C)	1 A

Reduced demand on support services	
23. It is suggested that there are potential benefits in including informal carers in pre-operative assessment/education, and post-operative intervention, to maximise service user independence and reduce carer stress. (Chow 2001, C)	2 C

Reintegration into the community	
24. It is recommended that occupational therapists encourage early discussion and goal setting for community reintegration, including social and physical activities. (De Groot et al 2008, D; Gillen et al 2007, C)	1 C
25. It is suggested that where specific needs are identified, the occupational therapist refers the service user on to community rehabilitation, reablement or intermediate care services to enhance community reintegration. (De Groot et al 2008, D; Gillen et al 2007, C)	2 C

Strength of grade

Strength	Grade	Benefits and risks	Implications
Strong	1 'It is recommended...'	Benefits appear to outweigh the risks (or vice versa) for the majority of the target group.	Most service users would want or should receive this course of intervention or action.
Conditional	2 'It is suggested....'	Risks and benefits are more closely balanced, or where there is more uncertainty in likely service user values and preferences.	The majority of service users would want this intervention but not all and therefore they should be supported to arrive at a decision for intervention consistent with the benefits and their values and preferences.

(After: Guyatt GH, Oxman AD, Kunz R, Falck-Ytter Y, Vist GE, Liberati A, Schünemann HJ; GRADE Working Group (2008) Rating quality of evidence and strength of recommendations: going from evidence to recommendations. *British Medical Journal*, 336(7652), 1049-1051.)

GRADE quality of evidence grading

Quality of evidence	Grading	Characteristics
High	Grade A	Based on consistent results from well-performed randomised controlled trials, or overwhelming evidence of an alternative source e.g. well-executed observational studies with strong effects.
Moderate	Grade B	Based on randomised controlled trials where there are serious flaws in conduct, inconsistency, indirectness, imprecise estimates, reporting bias or some other combination of these limitations, or from other study designs with special strengths.
Low	Grade C	Based on observational evidence, or from controlled trials with several very serious limitations.
Very low	Grade D	Based on case studies or expert opinion.

(After: GRADE Working Group (2004) Grading quality of evidence and strength of recommendations. *British Medical Journal*, 328(7454), 1490–1494.)

Guideline Reference: College of Occupational Therapists (2012) *Occupational therapy for adults undergoing total hip replacement*. London: COT.

The full practice guideline together with implementation resources can be found on the College of Occupational Therapists website:

<http://www.cot.co.uk/library-publications/cot-publications/practice-guidelines>.