Perceptions of Physiotherapy Best Practice in Total Knee Arthroplasty in Hospital Outpatient Settings

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ABSTRACT

Purpose: The primary purpose of this study was to examine experienced physiotherapists' perceptions of best practices for patients following total knee arthroplasty (TKA) in publicly funded outpatient hospital settings in the Greater Toronto Area (GTA). The secondary objective was to identify the facilitators of and barriers to implementing best practices in the subacute phase of rehabilitation.

Methods: A qualitative, descriptive, focused ethnographic approach was used to explore physiotherapists' perceptions of best practices for patients with TKA. In-depth semi-structured interviews were conducted with expert physiotherapists acting as key informants. A snowball sampling method was used to recruit physiotherapists in the GTA. Interviews were conducted in person by two of the investigators.

Results: Physiotherapists from seven acute-care hospitals in the GTA participated in the study. Analysis of the 140 pages of transcripts from the interviews with 10 physiotherapists revealed that participants perceived best practices as encompassing the adoption of a client-centred approach; inter-professional collaboration; aggressive rehabilitation for patients who are unsuccessful in achieving their outcomes; the use of relevant outcome measures; and consideration of the impact of scarce resources on care.

Conclusions: The findings of this study highlight physiotherapists' perceived best practices for patients with TKA and the unique contribution that hospital-based outpatient physiotherapy can make to patients' rehabilitation.

Key Words: best practice, osteoarthritis, physiotherapy, total knee arthroplasty

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RÉSUMÉ

Objectif : L'objectif principal de cette étude était d'analyser la façon dont les physiothérapeutes d'expérience perçoivent les pratiques exemplaires pour les patients à la suite d'une arthroplastie totale du genou (ATG) dans les hôpitaux à financement entièrement public dans la région du Grand Toronto. L'objectif secondaire était d'identifier les éléments facilitants et les obstacles à la mise en place de pratiques exemplaires lors de la phase subaiguë de la réadaptation.

Méthode : Une approche qualitative descriptive à caractère ethnographique a été utilisée pour explorer les perceptions des physiothérapeutes en ce qui a trait aux pratiques exemplaires pour les patients avec ATG. Des entrevues semi-structurées approfondies ont été réalisées avec des physiothérapeutes experts à titre d'informateurs principaux. Les physiothérapeutes de la région du Grand Toronto ont été recrutés selon une méthode de recrutement dite « en boule de neige ». Les entrevues ont été réalisées en personne, par deux des chercheurs.

Résultats : Les physiothérapeutes de sept hôpitaux de soins de courte durée de la région du Grand Toronto ont participé à l'étude. L'analyse des 140 pages de transcription de ces entrevues avec 10 physiothérapeutes a révélé que les participants estimaient que les pratiques exemplaires englobaient l'adoption d'une approche centrée sur le client et d'une collaboration interprofessionnelle, une réadaptation agressive des patients qui ne parviennent pas à atteindre les résultats attendus, l'utilisation de mesures de résultats pertinentes et la prise en compte des effets de la raréfaction des ressources en soins de santé.

Conclusions : Les constatations de cette étude viennent souligner ce que sont, pour les physiothérapeutes, les pratiques exemplaires pour les patients avec ATG et la contribution particulière de la physiothérapie en centre hospitalier à la réadaptation de patients externes.

Mots clés : arthroplastie totale du genou, arthrose, physiothérapie, pratique exemplaire

This research was conducted in partial fulfilment of the requirements for an MScPT degree at the University of Toronto.

The study was conducted at the University of Toronto and received ethics approval from the University of Toronto Research Ethics Board and from the Research Ethics Board of St. Joseph's Hospital, Toronto, Ontario.

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INTRODUCTION

Arthritis is the leading cause of pain and disability in Canada: more than 4 million people report that they have been diagnosed by a health professional as having this condition.¹ Arthritis frequently results in joint deterioration and orthopaedic surgery,^{2–4} specifically total knee arthroplasty (TKA), which has been shown to improve patient outcomes in a cost-effective manner.^{5–7}

The Canadian Institute for Health Information⁸ reports that the number of TKA surgeries has increased significantly in the past decade, with 37,943 hospitalizations for TKA (not including Quebec) in 2006/2007.^{8–10} This increase is attributed to Canada's ageing population, the increased prevalence of osteoarthritis, and rising obesity rates.¹¹ In addition, the indications for TKA have expanded with advances in prosthetic design and material and safer anaesthetic techniques, allowing both younger and older individuals, as well as those with multiple comorbidities, to be candidates for TKA.^{3,11,12} Canada has invested in reducing wait times for TKA since 2004.⁸ In Ontario, the number of TKA procedures increased by 32% from 2004/2005 to 2006/2007.⁸

A high proportion of patients are referred for rehabilitation following TKA.¹³ There are no evidenced-based practice guidelines to guide therapists caring for patients in subacute or post-hospital-discharge rehabilitation.¹⁰ For patients who undergo TKA for the treatment of osteoarthritis, physiotherapy in outpatient (OP) settings has been shown to improve functional activities of daily living, range of motion, stiffness, pain, and distance walked.^{5,14–16} However, there is no clear understanding of what constitutes best practice in the subacute phase of TKA rehabilitation after patients are discharged home.

Understanding what constitutes best practice for TKA patients in this phase is important to ensure the best use of valuable human resources, minimize lengthy wait lists, and facilitate optimum outcomes for patients. This is particularly crucial because patients are being discharged home earlier from acute-care hospitals to accommodate the increased number of TKA procedures, meaning that less time is available for acute physical recovery, rehabilitation, and education and that the burden of care for patients and their families is increased.^{8,10} Approximately 36% of patients who have a TKA are under 65 years of age and require appropriate rehabilitation to be able to resume work-related physical activities as quickly as possible.⁸ Given the limited number of publicly funded community rehabilitation centres and recent closures of OP rehabilitation centres in hospitals, there is a need to better study this phase of rehabilitation, since community-based health care providers have become responsible for a greater proportion of the rehabilitation process, including the monitoring of post-operative complications such as infection, deep-vein thrombosis, and anaemia.¹⁰

The purpose of this study was to investigate expert physiotherapists' perceptions of best practice for patients with TKA in publicly funded OP hospital settings in the Greater Toronto Area (GTA) and to identify the facilitators of and barriers to implementing best practices.

METHODS

A qualitative, descriptive (focused ethnographic) approach was used to explore physiotherapists' perceptions of best practices for patients with TKA. In-depth semi-structured interviews were conducted with expert physiotherapists acting as key informants.

Interview Guide

An interview guide was developed based on a literature review, the clinical experience of the investigators, and consultation with colleagues. An open-ended format allowed the researcher to avoid posing leading questions, in order to obtain a therapist's true perspective; for example, one question from the interview guide asked participants to "describe what you think best practice is with the TKA population." Probes/prompts and questions not included in the interview guide were used to encourage participants to elaborate on their responses and to elicit further discussion in a neutral manner.¹⁷ Participants were encouraged to share their thoughts, feelings, insights, and behaviours related to their perceptions of best practice with this population. At the conclusion of the interview, each participant was given an opportunity to share any additional comments.

The goal of qualitative research is to gain insight into the phenomenon being studied until a point of saturation is reached (i.e., until no new themes emerge from subsequent interviews). For the purposes of this study, it was anticipated that saturation would be reached after interviewing 8 to 10 participants.

Participants

The participants were expert physiotherapists with extensive experience in treating patients with TKA in the OP setting of publicly funded hospitals in the GTA. For the purposes of this study, an "expert" was defined as an individual with sustained clinical experience, current employment in an OP department managing patients with TKA, and involvement in related professional-development activities such as rounds, conferences, and research.

Recruitment

Participants were recruited using purposive methods. Specific individuals were selected based on their extensive experience with patients with total joint replacement, to allow researchers to gain rich, in-depth insight

into and understanding of the perceptions of best practice; a snowball sampling method was then used, whereby the initial participants contacted were asked to recommend others who might match our definition of "expert physiotherapist."^{18,19} Initial contacts were from the Total Joint Network, a partnership of organizations involved in orthopaedics within the GTA.²⁰ The objectives, requirements, and details of the study were explained, and an information letter and consent form were sent by e-mail, fax, or postal mail. If the physiotherapist consented to participate, a suitable interview time at a convenient meeting location was arranged.

Interviews

Each face-to-face interview lasted approximately 45–60 minutes and was conducted by one of two investigators (SM, ML), who were trained in conducting qualitative interviews prior to the data-collection process. The interview guide was not provided to participants in advance, as the goal was to discover their unedited, unpractised, and non-collaborative views. The interviews took place from March 2006 through June 2006. With the consent of each participant, interviews were audiotaped. The investigators also took field notes before, during, and after the interviews; these notes documented the investigator's thoughts on the interview itself, any non-verbal communication by participants, and any conversation not audiotaped before and after the interviews.

In the initial pilot interviews, some participants appeared hesitant when asked to describe their perceptions of best practice in the TKA population, asking, for example, "Am I telling you what you want? What information do you need exactly?" Based on the information gained from the first two interviews, the interview format was revised to permit a slower transition into the discussion of best practice. The investigators first asked participants what best practice means in general, then asked them to apply their definition to the population of interest. In subsequent interviews, the investigators stressed the importance of gathering participants' opinions and confirmed that there was no expectation of right or wrong answers.

Analysis

After each interview, the researchers listened to the audiotapes, which were then transcribed verbatim. The information was organized using NVivo version 2.0 software (QSR International Pty Ltd., Doncaster, Victoria, Australia) to identify key components. The transcripts and field notes were read and studied intensively as further data were collected, in order to identify key ideas and recurrent themes. Responses to open-ended questions were systematically grouped and coded based on content. An iterative/inductive coding scheme was developed as the transcripts and field notes were read.

The unmarked text was coded line by line (open coding).^{18,19} The codes were similar or repeated words found in the text. Similar codes were grouped into sections, a technique called *axial coding*, to create a detailed index of the data. This procedure organized the data into manageable chunks for subsequent retrieval and exploration. Similar codes were clustered together to generate themes/concepts. Reading larger blocks of text using the compare-and-contrast method was another approach used to identify themes.^{18,19} An independent assessment of transcripts by an additional researcher ensured credibility and confirmability. The combination of systematic record keeping, different data sources, and team analysis ensured the rigour and credibility of the research.

The study received ethics approval from the Health Sciences Research Ethics Board of the University of Toronto and the Research Ethics Boards of the relevant hospitals.

RESULTS

Participants

Ten physiotherapists from seven acute-care hospitals in the GTA participated in the study. Participants (3 male, 7 female) had a mean 13.5 years' experience (median: 15 years), and all held Bachelor of Science in Physiotherapy degrees, with the exception of one who held a Graduate Diploma in Physiotherapy (see Table 1). The researchers verified that all participants were involved in professional-development activities such as education/mentorship programmes specific to the TKR population (4); research (1); programme implementation or development (3); and committees specific to TKR, both internal and external (3).

Components of Best Practice

Analysis of the 140 pages of transcripts from the interviews with 10 physiotherapist participants revealed 5 key themes related to best practices in the management of patients with TKA in the hospital OP physiotherapy setting (see Table 2): (1) client-centred approach, (2) impact of resources on best practice, (3) inter-professional collaboration, (4) aggressive rehabilitation, and (5) use of relevant outcome measures.

1. Client-Centred Approach

All participants identified a client-centred approach as the cornerstone of best practice. They reported that although specific strength and ROM testing is important during recovery, knowing which activities are most important to the client is essential. Having clients play an active role in their rehabilitation was believed to optimize recovery within the shortest time. Participants

Table 1 Participant Demographics*

Sex	Year Graduated from PT School	Level of Schooling	Hospital Experience (years)	TKA Experience (years)	OP Experience (years)	TKA Caseload (%)
F	1999	BScPT	7	7	6	5
M	1998	BScPT	7	8	8	10
F	1989	Graduate Diploma in Physiotherapy	3	16	3	25–30
F	1982	BScPT	18	18	18	80
F	1985	BScPT	17	21	21	33
M	1999	BScPT	7	7	7	20
F	2000	BScPT	6	6	6	25
M	1977	BScPT	15	15	6	30
F	1970	BScPT	19	>10	>10	80
F	1979	BScPT	27	27	27	90

* Participants were involved in professional-development activities such as education/mentorship programmes specific to the TKR population (4); research (1); programme implementation/development (3); and committees specific to TKR, both internal and external (3).

Table 2 Summary of Components of Best Practice

Best Practices	Considerations—Elements and Challenges to Best Practice
Client-centred approach	<ul style="list-style-type: none"> Focus on activities most important to the client Education of clients at pre- and postoperative stages of recovery Active role for clients in their rehabilitation Understanding of common goals with the client
Impact of resources on best practice	<ul style="list-style-type: none"> Integrated care with smooth transitions along entire care continuum Resources to accommodate the increase in TKA volumes Access to OP and home care PT without restriction Different delivery models (e.g., groups) to address resource issues
Inter-professional collaboration	<ul style="list-style-type: none"> Easily accessible information on pre-op function, type of prosthesis, and team's expectations
Aggressive rehabilitation	<ul style="list-style-type: none"> Access to aggressive rehabilitation for patients who do not achieve optimal outcomes Physiotherapy expertise and experience for clients who need an aggressive approach to achieve mobility goals
Specified outcomes define best practice	<ul style="list-style-type: none"> Use of outcome and performance measures as they relate to client function and goals

indicated that gaining an understanding of a client's goals and working toward achieving these common goals is paramount:

... always following the patient, and certainly listening to the patients regarding their concerns and clearly stating the goals of the programme and asking the patient what their expectations are and always making sure the patient takes an active role in their therapy.

Another key component of client-centred care described as fundamental to best practice is patient education at the preoperative and postoperative stages of recovery:

I think there should be a lot of education going on preop. Here we have preop classes held every week for total knee patients, so during that class we tell them what to expect after the surgery and what exercises to do after surgery and before surgery ... I think that education preop is very important, and that makes a big difference in terms of recovery and best practice.

However, interviewees also reported that despite the importance of this element, there are gaps in education

at the preoperative stage, perhaps related to the challenges of providing care in the various settings through the continuum of care.

2. Impact of Resources on Best Practice

Integrated care with smooth transitions along the entire continuum of care was identified as an essential component of best practice; some participants reported that staffing and space reductions in their hospital OP facilities or a lack of subsidies to accommodate rehabilitation for the increase in TKA surgery volume has affected their ability to provide optimum care:

We really have been ramping up, and it is amazing the turnaround. The ministry is aware that there has been a waiting list that has been massive ... It is proving that we need a continuum of care, right—you can't just up the number, decrease your waiting list and not have rehab, because they are going to come through the back door with more surgery and complication.

As a result, some participants said, they have adapted by providing rehabilitation in groups in order to manage

their wait times as delays to hospital OP physiotherapy affect their ability to sustain best practice:

It's not really a class where you do identical treatment—it's just a class where you have the same group of people with the same diagnosis together doing similar things, not identical but similar things ... to save some time ... because we have like over a hundred people in a waiting list.

Participants discussed how the scarcity of publicly funded physiotherapy in the OP setting creates many challenges to best practice in rehabilitation, which hinders clients' achievement of outcomes post-TKA:

We have had some issues ... where patients are not being followed ... they don't have the funding to pay for physio, and home care can only go in a couple times a week, so there have been issues around that that we had to jump in on.

Most indicated that the lack of resources affects continuity of care through the health care system and challenges therapists' ability to provide optimum care. Delays in transferring patients from inpatient care to OP care and delays in receiving home care physiotherapy and coordinating OP physiotherapy after discharge were cited as examples of inefficiency that affect best practice. Participants felt that effective and ongoing communication with the surgeon and the entire team could overcome the fragmentation in the system to some degree.

3. Inter-professional Collaboration

Many participants reported that interaction and communication with other health care professionals, such as the surgeon or a previous therapist, is easier when therapists in the post-acute rehab phase are employed in an OP hospital setting:

... we attend weekly rounds—post-surgical and rheumatology rounds. We keep on top of all the evidence. We have a close association with the surgeons in the fracture clinic and up on the floors so we know what their expectations are. We have weekly debriefings on some of the complex patients in the fracture clinic with those surgeons.

Participants reported that having information such as patients' preoperative function, the type of prosthesis used, and surgeons' expectations is helpful to postoperative rehab management. Some participants reported that outcome measurements taken at preadmission and accessible to the hospital OP physiotherapists allow them to understand the preoperative status of their clients and then deliver effective therapy:

I found that what has worked really well is knowing right from the time of preop visit what the patient's range of motion is, what the strength is like, how they were able to function in terms of the WOMAC and timed up-and-go, and to get a clear picture of what they were like before and then really setting clear guidelines for the patient and how long they will be coming for.

Participants noted that communication between health care providers is essential to their practice. They emphasized that health care practitioners in different settings need to be knowledgeable and comfortable in the management of patients with TKR, which often requires a more aggressive rehab approach.

4. Aggressive Rehabilitation

Participants agreed that the majority of patients receiving treatment in the hospital OP physiotherapy department are those who have not achieved optimal outcomes with treatment provided elsewhere. They clarified that aggressive rehabilitation is essential for optimal outcomes for some patients following TKA:

... when I get them [patients] they have flexion contractures, and we try to work with straightening as well as the bending, so they are not as easy to work with, but I don't believe that they [therapists] are as aggressive on the home visits.

Participants explained that because their caseload includes a high volume of total joint replacement, their experience in managing this population is greater, and they know when to be more aggressive in achieving mobility goals. This expertise allows them to provide effective care for patients who have failed to reach their rehabilitation goals in other settings:

We are finding now just from the patients that have come back [from the community] ... either they [therapists] don't have the experience to deal with them, or they are too gentle ..., or they [patients] have been left to do a lot of their own independent programmes and they are not being pushed.

Many participants indicated that they can easily access surgeons' input on their patients' progress; as a result, they are aware of the surgeon's expectations. In addition, if a patient is not progressing as he or she should, they can easily consult with the surgeon. This relationship, they explained, facilitates best practice:

... access to the doctors in fracture clinic ... so if I have his [the surgeon's] patient then I can ask him personally about questions related to them [the patient] ... we are able to see the x-rays and ask about different things to do with different types of total knees and any advancements ...

Participants agreed that the outcomes of aggressive physiotherapy should be met within 8 weeks, as the knee can become stiff as a result of tissue scarring down from lack of mobility.

5. Specified Outcomes Define Best Practice

Participants noted that achievement of certain outcomes reflects best practice. Range of motion (ROM) was the most important outcome measure: participants reported that they look for knee flexion of 90° within the

first 6 weeks, with progression to 110° of knee flexion and a zero quadriceps lag by 8 weeks. These outcomes are important because they enable patients to carry out their daily activities; for example, 110° of knee flexion is necessary for reciprocal stair walking. All participants indicated that they measure ROM on a regular basis (i.e., at each appointment). Performance measures such as the timed up-and-go, strength testing, timed stair test, and 2-minute walk test were reported less frequently (at initial assessment, every 2–3 weeks, and at discharge). Participants also reported using outcome measures such as the Lower Extremity Functional Scale and Western Ontario and McMaster Universities Osteoarthritis Index, in addition to incorporating functional activities into their treatment as a component of best practice:

As far as the components of the treatment programme go along with each patient, I think it is important to do things that are most functional, so incorporating activities like stairs or step, walking, doing squats, things that translate into everyday activities. We try and get to 120° and 0° extension and a 4+ quadriceps strength within 8 weeks.

Summary

Five elements were identified as best practice in TKA subacute care. When these elements are integrated, best practice for TKA is perceived as involving a client-centred care approach with interdisciplinary collaboration in an integrated health system that supports care throughout the continuum. For physiotherapy in particular, best practice encompasses specific outcomes to measure client improvement and having the confidence to adopt an aggressive approach for patients who have not reached their goals.

DISCUSSION

The primary objective of this study was to explore physiotherapists' perceptions of the components of best practice for patients who are post-TKA, specifically in the hospital OP setting. The Canadian Physiotherapy Association provides a working definition of best practice as follows:

Best practice recognizes that evidence-based physiotherapy practice incorporates knowledge generation, synthesis, transfer and adoption. In clinical practice, physiotherapists readily integrate the best current research with clinical expertise, client values, and available resources to achieve best results for their clients.²¹

Our interviews with expert physiotherapists revealed how physiotherapists define components of best practice in their own hospital setting. Participants discussed their perceptions of best practices in the context of their

extensive clinical experience in managing TKA patients who are not successful in conventional OP or home physiotherapy; the outcomes that need to be achieved; the value of their collaborative relationships with others, including orthopaedic surgeons; and a client-centred approach to care in the context of the system in which they practise.

Participants in this study concurred with others^{14,22,23} that many patients can meet desired outcomes with conventional OP or home care physiotherapy in the community. For example, Mockford et al.¹⁴ found that both patients given a home exercise programme and those who had OP physiotherapy had improved ROM at 3 months and 12 months after surgery. At 1-year follow-up, patients who received OP physiotherapy had achieved a greater change in range of active knee flexion (10.1° mean difference) than those given home exercise programmes (6.2° mean difference). These differences, while not statistically significant, may be clinically important, especially at 3 months, since functional ROM of the knee could potentially allow earlier return to work. This may not have been an important consideration in Mockford's study, as his population was older (69 years OP group; 70 years home exercises group); however, TKA is increasingly being performed on younger patients,^{3,10} some of whom are still in the workforce.

Our results support the findings of others in that knee ROM is considered to be one of the primary indicators of a successful TKA.^{12,24} Participants in our study felt that it is best practice to strive for an outcome of 110° of flexion and full extension, with no quadriceps lag, by 8 weeks. Full extension was deemed necessary because with a flexion contracture or quadriceps lag, gait alterations can arise that result in increased energy consumption.¹⁵ The importance of performance measures has also been reported in the literature, and this needs to be considered in developing guidelines for the management of this population in the OP setting.¹⁰

Aggressive physiotherapy within the first 6–8 weeks post TKA was considered a component of best practice to achieve satisfactory outcomes and meet patients' expectations for recovery. This perception is supported by Moffet et al.'s⁵ findings in a study comparing an intensive functional rehabilitation (IFR) programme comprising 12 individual physiotherapy sessions and home exercise with standard care (home exercises).⁵ Their study revealed that the IFR group had less pain, stiffness, and difficulty in performing daily activities in the short term, although long-term results were similar for both groups.⁵

While participants in this study consider it best practice for TKA patients who have not been successful in community-based therapy to attend hospital OP physiotherapy, there are indications that accessing this service and expertise may be a challenge in the current system. Landry et al.²⁵ identified a trend toward closures, reduc-

tions, and limited access to OP physiotherapy in hospitals in Ontario. These hospital closures, combined with the delisting and scarcity of community-based publicly funded physiotherapy clinics, may threaten patients' access to publicly funded physiotherapy. It is therefore imperative to use these scarce hospital specialty resources wisely by determining, in future studies, which patients will benefit from a more aggressive hospital-based approach and which will improve with less intensive OP or home programmes.

A client-centred approach to care was considered an essential component of best practice in TKA rehabilitation. This finding is similar to those of other studies in which clinicians reported that having clients participate proactively in their care by setting goals, being aware of appropriate time frames of treatment, having clear expectations of their prognosis and outcomes, and fostering independence with their exercise programme are important concepts in a client-centred care approach, which is considered paramount in best practice.^{26,27} Clients who are happy with the goals of their rehabilitation and believe in its efficacy have better rehabilitation outcomes.^{26,28} In order to implement best practice with this population, the client and the entire team need to be appropriately educated.²⁹ Participants whose facilities deliver preoperative education sessions clearly articulated this as an important component of best practice. Preoperative physiotherapy and educational sessions are considered an element of best practice to ensure that patients understand the preoperative requirements, the surgical procedure, postoperative care, and the necessary home/activity modifications, as well as to reduce hospital length of stay.^{30,31}

Limitations

This study explored perceptions of best practice in TKA of physical therapists employed in hospital settings. Their perceptions of best practice may be different from those of therapists who work in other environments and may not reflect patients' perceptions of best practice.

CONCLUSIONS

Best practice in the management of the TKA patient requires a client-centred approach involving aggressive physiotherapy that has specified outcomes. Communication through the continuum of care and within the health care team is essential to best practice and supports the proper allocation of OP physiotherapy resources. Access to OP physiotherapy for those without extended health benefits or the financial means to pay out of pocket has become challenging. Working groups such as the Bone and Joint Health Network³² are committed to the development and implementation of best practice guidelines for the management of TKA patients in Ontario. The knowledge gained from this study may

serve as a starting point to guide the future direction of and foster consensus on the physiotherapy management of TKA patients in the subacute phase of rehabilitation.

KEY MESSAGES

What Is Already Known on This Topic

Post-TKA patients receive physiotherapy in the hospital phase, and most receive physiotherapy in some form after discharge from the hospital. The current literature indicates that physiotherapy has benefits after TKA; however, there are no best practice guidelines for the management of TKA patients.

What This Study Adds

This is the first study to provide insight into the key elements of best practice for patients in the subacute phase of rehabilitation post TKA from the perspective of physiotherapists who work in publicly funded hospital OP settings. Collaborative, client-centred care; adequate resources; the use of relevant outcome measures; and intensive, aggressive therapy are essential best-practice considerations for TKA patients receiving outpatient physiotherapy in the subacute phase.

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