

Hip replacement

Information and advice for patients

Trauma & Orthopaedics

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What is a hip replacement?

A hip replacement is an operation to replace a severely damaged hip joint. The hip joint is made up of 2 parts:

1. **the socket** – a cup shaped bone called the acetabulum
2. **the ball** – the head of the thigh bone, called the femur

A hip replacement involves replacing the socket and ball with metal, ceramic or plastic implants.

At Sandwell and West Birmingham Hospitals NHS Trust all hip replacements are done at Sandwell General Hospital.

Why do people need knee replacements?

The hip is an important weight-bearing joint that gives your leg a wide range of movement. The joint surfaces are normally covered by a very strong elastic tissue called cartilage. Normally the cartilage is smooth and allows the joint to move smoothly and bear weight without pain.

As you get older the cartilage can wear away so the bone is exposed. This causes the two bones to rub against each other which causes pain. This is a simplified reason as to why osteoarthritis occurs. Osteoarthritis can be a very painful disorder which may slow down your mobility, walking or even stop you from sleeping.

Deciding to have a hip replacement

A hip replacement is an elective operation, which means it is an operation you choose to have done to relieve your symptoms. The decision to have the operation is not made by the doctor, but it is you who must weigh up the benefits against the risks. It is important that you understand what the procedure involves and that all your questions have been answered.

If you choose to have the operation it is important that you have it at a time that suits you because you must be totally focused on your recovery and able to give it your full attention. For example, if you're moving house or expecting the birth of a grandchild it may not be the best time to have your operation.

What are the benefits of a hip replacement?

The benefit of a hip replacement is that it reduces pain. Reduced pain can help you to walk, sleep and perform your normal daily activities better, thus improving your quality of life. However, you shouldn't expect your new hip to be as good as it was in your youth.

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What are the risks of having a hip replacement?

Common risks

Pain:

Yolt is normal to experience some pain after the operation. You will be given painkillers to help relieve this and the pain will improve in time, however some patients can experience long-term pain after a hip replacement.

Blood clots:

6 – 7 out of 100 people develop a blood clot in a vein in their leg (deep vein thrombosis/ DVT) after knee replacement surgery. A DVT is not a major problem in itself, but the clot can move to the lungs causing a pulmonary embolism (PE), which is serious and can be fatal. A PE occurs in 3 – 4 out of 1000 patients after this surgery.

You are more likely to develop a blood clot if you are immobile, are overweight, smoke or are on hormone replacement therapy (HRT). Therefore you are strongly advised to lose weight and stop smoking / HRT before your operation, move about as much as possible and not go on any long car journeys or flights for 4 weeks before surgery and for 3 months afterwards.

To reduce your risk of developing a DVT you will be given blood-thinning injections or tablets for 10 days after surgery and will be asked to wear tight stockings.

Bleeding:

A small amount of bleeding is not uncommon after the operation, but some patients may experience bleeding that is heavy enough to need treatment such as a blood transfusion, iron tablets or surgery. This occurs in 2 – 4 out of 100 patients.

Infection:

There is a risk that you could develop an infection in your wound or the implant after surgery. This occurs in 5 – 26 out of 1000 patients and is more likely to occur if you are carrying an infection before the operation, as infection anywhere in your body (e.g. your chest, skin or urine) can spread to your joints.

An infection can usually be treated with antibiotics, but some people need surgery to 'washout' the joint or remove the implants which would be replaced with further surgery. In some cases a severe infection can cause a blood infection.

To reduce your risk of developing an infection after surgery we will check for signs of infection at your pre-operative assessment appointment and will check that you are not carrying MRSA on your skin. MRSA lives harmlessly on the skin of many people but can cause serious infection if it gets into a wound and is very difficult to treat. If you have an infection

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or are carrying MRSA you will not be able to have your operation until you are clear. You must see a dentist before your operation to check you have no potential sources of infection in your mouth.

You will also be given antibiotics just before and after the operation to help prevent infection.

Problems passing urine (urinary retention):

4 – 5 out of 10 patients have trouble passing urine in the first 24 hours after surgery either due to the anaesthetic or not being able to stand up. If this occurs you may need to have a tube inserted into your bladder (catheter) to drain the urine until you are mobile.

Constipation:

3 – 12 out of 100 people become constipated for a short time after the operation. If you become constipated you may be offered laxatives, suppositories or an enema.

Constipation can be prevented by:

- Eating plenty of fibre
- Moving around the ward
- Drinking plenty of water

Altered leg length:

It is common for the operated leg to be up to 1cm shorter or longer than the other leg after a hip replacement and this difference should not be noticeable to you. Every effort will be made to ensure both legs are of equal length. A difference of more than 1cm is rare and would require a special raised shoe or possibly surgery to correct.

The implant needs replacing:

6 – 13 out of 100 patients need to have their hip replaced again in the future. This can be because the implant has become loose due to wear and tear, or there is an infection in the joint.

Less common risks

Joint dislocation:

During your operation the surgeon will have to dislocate (pop out) your thigh bone from your hip socket. This stretches the muscles and tissues around your hip which means there is a risk it could dislocate again in the future; the risk of this occurring is highest in the first 3 months while all the soft tissues are healing. The hip could also dislocate due to wear and tear. Hip dislocation after hip replacement occurs in 3 – 4 out of 100 patients.

If this occurs, the joint can usually be put back into place without surgery. Sometimes this is

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not possible and an operation is required, followed by the application of a hip brace. In rare cases the hip may keep dislocating which would require an operation to fix this. Your new hip is less likely to dislocate if you follow the occupational therapy advice on pages 26-30.

Nerve damage:

The nerves around the hip, particularly the sciatic nerve, can be damaged during surgery. This occurs in 1 – 2 out of 100 patients and may cause temporary or permanent altered sensation along the leg.

Scarring:

When your wound has healed you will have a scar. In some people the wound can become red, thickened and painful; this is more common in Afro-Caribbean people. Massaging the scar can help reduce its appearance.

Bone damage:

The thigh bone may be broken when the implant is inserted and this may need to be operated on during the operation or with a further operation. This occurs in less than 1 in 100 patients.

Rare risks

Kidney problems:

5 out of 1000 patients develop acute kidney injury after this operation. This means that the kidneys aren't able to remove water, salt and waste products properly. If this happens you will need treatment to correct this, and maintain the correct levels of water and salt in your body.

Blood vessel damage:

The vessels around the knee can be damaged and require further surgery to repair the damage. This occurs in less than 1 in 1000 patients.

Death:

3 – 4 out of 1000 patients die from complications of joint replacement surgery, such as a pulmonary embolus.

What are the risks of not having a hip replacement?

If you choose to decline hip replacement surgery the arthritis in your hip will gradually worsen over time and lead to increasing pain and/or reduced mobility.

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Are there any alternatives?

Before opting for surgery you should try the following methods to try to reduce your pain and improve your mobility:

- Losing weight
- Avoiding strenuous exercises or work
- Using a stick or a crutch
- Medicines, such as anti-inflammatory drugs or steroids
- Physiotherapy and gentle exercises

Some of the above are not appropriate if you want to regain as much physical activity as possible, but you should discuss all possibilities with your surgeon.

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Preparing for a hip replacement

The Hip & Knee Club

Before having a knee replacement you are required to attend the Hip & Knee Club. This is an educational session where you will be given:

- Information about your operation and anaesthetic
- An opportunity to look at the hip prosthesis
- Information on pain management
- Exercises to strengthen your muscles
- Advice on what we expect from you and you can expect from us
- Advice on discharge planning
- A DVD for you to watch at home
- Contact numbers to answer future questions
- Advice on what we expect from you and what you can expect from us

This Hip & Knee Club is a group session, lasting 1-2 hours that will give you the opportunity to discuss any issues or concerns, not only with the speakers but also with other patients and relatives who are possibly feeling the same as you. You will also be measured for any equipment you may need to loan after your operation.

Pre-admission clinic

A few weeks before your operation you will be seen in pre-admission clinic by a nurse or a surgical care practitioner. This is to check that you are as fit as possible for the anaesthetic and operation. At the appointment you will be asked questions about your:

- social circumstances
- medical and surgical history
- allergies (e.g. nuts, eggs, metal)
- current medication

It can be useful to bring your medication with you and if you are unsure your GP should be able to give you a summary.

At the pre-admission clinic you will be weighed and have your blood pressure taken. You may then have other tests such as:

- **ECG (electrocardiogram)** – this involves electrodes (small sticky patches) being placed on your skin to record the activity of your heart.
- **Blood test** – to see what is normal for you and to find any abnormalities.

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- **X-Rays** – to check your lungs and neck.
- **Urine test** – to check for infection, abnormalities and pregnancy (if appropriate).
- **MRSA screening** – swabs taken from your nose and groin to test for MRSA.

Your pre-admission clinic appointment also gives you the opportunity to ask any questions that you may have thought of since attending the Hip & Knee Club.

The nursing staff will give you an antiseptic solution to take home with you, which you will need to shower with the night before and on the morning of your operation.

It is also important that you see a dentist before your operation to check that you have no potential sources of infection in your mouth as infection anywhere in your body can spread to your joints.

Preparing for returning home after surgery

Make sure you have at least one sturdy and safe banister on your stairs (two banisters are rarely necessary).

After surgery you should not attempt to get into a bath for some time, so if you only have a bath or your shower is over your bath you may want to fit a walk in shower. However, most people are happy to have a wash at the sink for this time.

You will not be able to do heavy housework, walk long distances or carry shopping bags for up to 3 months after surgery so make sure you have someone who can help you with these things.

You will also not be allowed to bend down to your feet, so make sure you have someone who can help you with foot care.

Most people prefer to have a friend or relative help with these things. These arrangements should be made before you come in to hospital as far as possible. If necessary, your GP surgery can arrange help from social services to help with personal care, although this may be means tested. Social services will not help you with shopping or housework. Some short term help may be available from the British Red Cross 'Home from Hospital Scheme'.

Occupational therapy

Occupational therapists can assess your home environment and lifestyle and help you make adaptations so that you can perform the things you need to in your daily life and be able to live as independently as possible. The advice they give you will help to protect your new hip. Before you come into hospital an occupational therapist will speak to you over the phone to:

- gather information about your home environment;

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- assess if you will need additional support at home after your operation;
- discuss any equipment or minor home adaptations that you may need.

The equipment they give you and any adaptations they suggest to your home will:

- Keep your new hip joint safe
- Make daily activities more comfortable
- Speed up your discharge home if everything is already in place

If you feel you may struggle with any activities at home, please talk to us about this and we can explore solutions with you.

Physiotherapy

At the Hip & Knee Club you will be given some routine exercises to do before and after your surgery. You can find these exercises on page 20. It is important to begin exercising your muscles as soon as possible and perform the exercises regularly in the weeks leading up to your operation.

Patient Reported Outcome Measures (PROMs)

All NHS health care providers are required to collect information about the outcomes of hip replacement surgery. This includes questions about your health and quality of life before and after surgery. You will be asked to complete a questionnaire (PROMs) before and after your operation. This information is then used to improve the quality of care for all patients.

The National Joint Registry (NJR)

You will also be asked to sign a consent form giving permission for your details to be placed on the National Joint Registry (NJR). The NJR collects information on hip and knee replacement operations in England and Wales to help find out which are the best performing implants and the most effective types of surgery. Your details can help to maintain high standards of care for other patients by giving information about the outcomes of joint replacement surgery, the performance of different implants and the performance of hospitals to healthcare professionals, patients, suppliers of implants and regulatory authorities.

The NJR records which implant you received during surgery so if a problem is identified with that particular one in the future they can identify which patients received it.

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The day of your operation

You should have nothing to eat or drink (nil by mouth) from midnight on the night before you come in to hospital for your operation. The only exception to this is if you are given special carbohydrate drinks, which will come with instructions.

Before coming into hospital

Before leaving home you will need to ring the ward to check that a bed is available for you. We always try to ensure a bed is available but there are times we are unable to do so due to unforeseen circumstances.

Please bring a pair of trainers or flat lace-up shoes into hospital with you for walking around after your operation, as backless or heeled shoes and slippers can be dangerous.

When you arrive at the ward

Once you have settled into the ward you will be seen by a doctor who will answer any questions you may have, take or confirm your consent, and mark the limb that is being operated on with an arrow. He/she will give you a rough idea of when you will go for your operation and we suggest you rest until then.

The nursing staff will give you any medication you need before surgery. They will also make sure you have showered and will give you a theatre gown to change into.

Whilst on the ward you also may be measured for compression stockings which you will wear during your stay and for 6 weeks after your operation to help prevent blood clots forming in your legs.

On the ward you will be seen by an anaesthetist who will discuss with you the safest type of anaesthesia for you. They will answer any questions you may have about the anaesthetic at this point. There are 3 main types of anaesthetic used for joint surgery:

General anaesthesia

This is when you are put to sleep. The anaesthetic will be given via the cannula in your hand. A mask may be placed over your face to give you oxygen while you fall asleep. Once you are asleep a tube is put down your throat to maintain your airway and administer gases to keep you asleep and pain free throughout the operation.

Spinal anaesthetic (a form of regional anaesthesia)

This procedure is performed more frequently as the side effects are less and patients are able to eat and drink immediately post operatively.

The spinal anaesthetic is performed either with you lying on your side or sitting up. Your

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lower back is cleaned with a solution that may feel cold and sterile drapes are applied. Your skin is numbed with a local anaesthetic and then another injection is inserted into your spinal column. The anaesthetist will inject an anaesthetic agent that will numb you from the waist down.

Epidural anaesthetic (a form of regional anaesthesia)

This procedure is very similar to the spinal anaesthetic; the difference is that a very thin tube is left in the epidural space in your spine. It is secured in position by tape to give a longer duration of anaesthetic and may be used for post operative pain control. You will have no control of your bladder while the epidural is in place so you will have a catheter (a tube into your bladder) that will drain your urine directly into a bag.

If you have a spinal or epidural anaesthetic you will be awake during the procedure. Please don't worry about seeing or hearing things; screens will prevent you from seeing anything and you can bring in your own personal DVD player, CD or tapes to listen to throughout the operation. If you are still worried you can discuss things with the anaesthetist who may be able to give you a sedative to make you feel sleepy.

What are the risks of the anaesthetic?

The anaesthetist will discuss the risks and potential complications of your anaesthetic, and you will be given a separate booklet called 'You and your anaesthetic' which has been produced by the Royal College of Anaesthetists which describes the risks.

Your operation

When it is time for your operation a member of the theatre staff will come to take you to theatre you will be checked out of the ward by a nurse. You will need to remove your underwear and jewellery at this point but can keep your wedding ring on provided that it is taped over. If you wear dentures and/or glasses these can be removed when you arrive in the theatre reception but please make sure you have a receptacle with your name on to put them in so they can be returned to the ward with the nurse.

You will be away from the ward for about 3 hours, but your operation does not take all this time; it is split between your anaesthetic, your operation and time spent in recovery.

In the theatre reception you will be asked a number of questions to ensure we know who you are; what you are having done and that you still wish to proceed.

ECG dots will be put on your chest to monitor your heart, a blood pressure cuff will be put around your arm and a pulse oximeter will be placed on your finger to monitor your oxygen levels and pulse.

You will then have a cannula (needle with a plastic port) inserted into a vein on your hand

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to allow drugs or fluids to be given directly into your blood stream and your anaesthetic will then be administered. Once this has taken effect your operation will begin:

1. You will lie on the side of your body that is not being operated on.
2. Your skin will be cleaned with anti-septic solution and clean drapes (towels) will be wrapped around your hip.
3. The top of your thigh bone (femur) which forms the neck and ball will be cut away and a replacement neck and ball will be put in. The implant can be made of different types of metals, polyethylene (like plastic) or very tough ceramic.
4. The socket (cup) part of the hip joint will be made smooth by removing the arthritic bone.
5. In some cases the surgeon may use a bone cement to hold the new ball and cup in position.
6. When the surgeon is happy with the position and movements of your hip, the tissue and skin can be closed. This may be done with stitches (sutures) or metal clips (skin staples).

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After having a hip replacement

After your operation you may have drains in your wound to take away excess blood from the operation site. If a drain is inserted it will be taken out the day after your operation by the nursing staff on the ward.

It is likely that your leg will be swollen after the operation. Do not worry if your leg swells up significantly. As you become more mobile the swelling will decrease.

Pain relief after your operation

You will be in pain after your operation but it should not be severe and we will try to ease it. Your pain is assessed using a pain scale of 1-4, where 1 is no pain and 4 is the worse pain you have ever had. This informs us which kind of pain relief you need. Forms of pain relief you may be given include:

Regional Blocks

Anaesthetic injected around the nerves that supply the operated area. These are usually performed in the anaesthetic room by an anaesthetist.

Patient Controlled Analgesia (PCA)

This is a hand held unit that allows you to give yourself pain relief as required. The drugs used are opioids, such as morphine. You will not be able to overdose. As opioids can make you sleepy you must wear oxygen while the machine is attached to you.

Skin patches

A number of pain-relieving drugs can be delivered through your skin via self adhesive patches however this is not used routinely for all patients having a knee replacement.

Oral medication (tablets, suspensions etc)

This is the most popular and frequently used method of taking medication.

Pain relief via the rectum (PR)

This can be seen as an unpleasant method of giving pain relief but it is an excellent method as the suppositories work for longer and can be self-administered.

Injections

Pain killing injections can be given, but are not used often. Injections may also be used to give drugs to stop nausea and vomiting.

Local infiltration of the joint

During the operation the surgeon may inject a mixture of long and short acting local anaesthetic into and around your knee.

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X-ray

Your knee will be x-rayed on day 1 after surgery. This is just to check the position of the implants and it does not usually affect your rehabilitation.

Physiotherapy

After surgery you should start doing the following exercises as soon as you are able. You should also practice them regularly before your operation. Doing these exercises will help to:

- Relieve pain
- Maintain muscle strength, joint movement and balance
- Prevent chest infections, constipation, pressure sores and blood clots

Circulatory exercise

You can perform this exercise in bed or when sitting in a chair. Point your foot away from you then towards you as far as it will go.

Buttock squeezing

You can perform this exercise in bed or when sitting in a chair.

1. Squeeze your buttocks together as tightly as possible
2. Hold for 5 seconds
3. Relax

Knee straightening

You can perform this exercise in bed or when sitting in a chair with your leg out in front of you.

1. Straighten your leg as much as possible while tightening the muscles on top of your thigh
2. Push your leg downwards
3. Hold for 5 seconds
4. Relax

When you get up for the first time the physiotherapist will advise you how to do so safely to avoid dislocation.

You must not:

- Cross your legs
- Bend more than 90° (a right angle) at the hip
- Twist your legs

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Occupational Therapy

After your surgery an occupational therapist will come to see you and will demonstrate and practice new techniques for:

- Washing and dressing the lower half of your body
- Getting in and out of bed
- Transferring on and off chairs and toilets
- Getting in and out of a car
- Domestic activities such as making drinks and meals (if required)

Rehabilitation contract

Every day you are in hospital a physiotherapist will come and see you and agree rehabilitation goals with you. All patients have different needs but a typical program would be as follows:

Day of surgery

- Drink and eat light food
- Take a few steps
- Sit in a chair
- Continue with your exercises unsupervised

Day 1 after surgery

- Eat and drink normally
- Walk a short distance with a frame
- Continue with your exercises

Day 2 or 3 after surgery

- Get showered and dressed
- Walk with sticks or crutches
- Practice walking up and down stairs
- Discharge home

As you progress, the physiotherapist will advise you how to safely get around on the ward.

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Going home

You can expect to be in hospital for about 2-3 days, although some patients require longer than this. Hospitals are for ill people and patients who have had joint replacements are not ill – in fact most patients go home feeling much better than when they came in because their arthritis pain has gone. Your discharge day is planned from the day you are admitted to hospital, so you and your relatives will know when this is.

Intermediate care

Some patients will need longer than others to achieve their rehabilitation goals. However, these goals do not have to be met in hospital and we do not recommend staying in hospital once you are medically well.

Patients needing longer than 3 days to be fit to go home may be offered an intermediate care bed, rehabilitation in hospital or intermediate care at home. These facilities are dedicated to rehabilitation and they only accept clients after a detailed assessment. Intermediate care is not convalescence (bed rest); you will be getting up and walking around. You will be expected to work hard to achieve your goals everyday during your stay and will be discharged as soon as you are safe to go home.

On discharge you will be given:

- An appointment to have your sutures or clips removed. These are removed at around day 10-21 either by a district nurse or in the hospital
- A follow-up appointment for 6 weeks time
- A 1 week supply of medication.
- A discharge summary
- Any other information relating to your procedure

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After discharge home

Once you are at home you will need to continue to wear your compression stockings for the next 6 weeks and should not go on any long car journeys or flights for the next 3 months. You should also not do any heavy housework, carry shopping bags or get into a bath until your doctor or nurse advises you it is safe to do so. It is also advisable to avoid sexual intercourse for the first 6 weeks after surgery.

Your wound

All wounds progress through several stages of healing. Depending upon your treatment you may experience such sensations as tingling, numbness and itching. You may also feel a slight pulling around the stitches or clips, or a hard lump forming. These are perfectly normal and are part of the healing process. It is also perfectly normal for your operated leg to swell for up to 6 months after the surgery.

To prevent infection developing it is important to take good care of your wound, as instructed by your doctor or nurse. If you visit the dentist in the next few months you must tell them that you have recently had joint replacement surgery.

Managing pain

Once at home you should control any pain or discomfort by:

- Taking your pain medicine at least 30 minutes before doing the exercises given to you by your therapist.
- Gradually weaning yourself off any prescription medication for pain over a period of time depending on the severity of your pain.

If what you have been prescribed is not relieving your pain, or the pain is becoming worse, please see your GP.

Sex

It is advisable to avoid sexual intercourse for at least 6 weeks after surgery. When you feel ready take things slowly and think about the position of your hip.

Women may find it more comfortable lying on their operated side and it is recommended that they continue with this method indefinitely to avoid dislocation.

Men may find it more comfortable lying on their back which they should continue to do for approximately 4 months after surgery. After this you may resume your preferred position.

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Physiotherapy and Occupational Therapy

The tissues and muscles around your new knee will take time to heal so it is important to continue the exercises given to you by the physiotherapist daily and follow the occupational therapist's advice below:

DO:

- Go for regular short walks
- Walk on level ground
- Sit on a firm high chair
- Take small steps when turning around
- Take care getting out of bed
- Continue using your sticks until you see the doctor in clinic

DO NOT:

- Kneel down
- Go for long walks
- Drive until your doctor says you can
- Go on long car journeys
- Bend your operated leg up too far
- Cross your legs or take your operated leg across your body

Most patients use both sticks for 6 weeks. If you have elbow crutches you may be told to use them for 3-6 months.

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Occupational therapy advice

Sleeping

You should sleep on your back with a pillow between your legs to prevent you from crossing them whilst you are asleep. You may want to practice sleeping like this before your operation.

You may need to change the side of the bed that you sleep on as you need to get in to bed with your UNOPERATED leg first and out of bed with your OPERATED leg first.

Getting into bed

1. Position yourself approximately half to two thirds of the way between the pillow and the end of the bed.
2. Reach back for the bed with both hands.
3. Extend the operated leg in front of you and sit down.
4. Position yourself so that your shoulders are pointing at the far top corner of the bed.
5. Push through your hands to move your bottom as far back onto the bed as you can.
6. As your feet begin to leave the floor, slowly lift your legs on to the bed as you pivot on your bottom.
7. Keep your operated leg as straight as possible and in line with your body at all times.

Getting out of bed

1. Sit up in bed and slowly 'step' your legs towards the edge of the bed pivoting on your bottom. Keep your operated leg as straight as you can and in line with your body.
2. Allow your operated leg followed by your un-operated leg to gently move towards the floor. Keep your operated leg as straight as you can but bend the un-operated leg and put that foot flat on the floor.
3. Place both hands on the bed at either side of your hips and push up from sitting to standing.
4. As you stand you can draw the operated leg back towards your body and put weight on it.
5. You should only take hold of your zimmer frame or sticks when you are standing and balanced – NEVER pull up on these as they may tip over.

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Bathing/showering

You should not get in or out of a bath for up to 12 weeks after your operation as you could fall or slip which could cause damage to your new hip. You should also not use a bath seat or lift until you are told you otherwise. If you have walk-in flat access shower please discuss this with us to see if it suitable for you to use.

We recommend strip-washing at the sink for the first 12 weeks after your operation and we may provide a perching stool for you to sit on whilst you do this if necessary.

Sitting

After your hip operation it is advisable to sit on a chair that has 2 arms as this will make standing and sitting easier and safer. The chair also needs to be at a safe height and the occupational therapists may raise your chair if it is too low.

From sitting to standing

1. Shuffle your bottom to the front of the seat whilst keeping your operated leg out in front of you with the knee as straight as possible.
2. Place both hands on the arms of the chair and use your upper body strength to push up to a standing position.
3. On standing draw your operated leg in line with your body. Only reach for your zimmer frame or sticks when you are balanced.

From standing to sitting

1. Position yourself so you can feel the seat of the chair with the backs of your legs.
2. Reach back for the arms of the chair one hand at a time.
3. Slide the operated leg out in front of you keeping the knee as straight as possible.
4. Slowly sit down onto the chair and then move your bottom to the back of the chair so you are sitting comfortably.

Using the toilet

The occupational therapist may recommend a raised toilet seat and/or toilet frame or grab rails to assist with getting on/off the toilet safely. Transferring on and off the toilet will then be similar to getting on/off a chair.

Getting on

1. Feel the toilet seat on the back of your legs before sitting.
2. Extend your operated leg in front of you.
3. Reach back one hand at a time for the frame or rails and then sit slowly.

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Getting off

1. Place both hands on the frame or rails (or toilet seat if no rails are available).
2. Push up to a standing position keeping the operated leg extended in front of you.
3. Draw the operated leg towards your body as you stand.

Using a car

You will not be able to drive after your operation until your consultant decides that it is safe for you to do so. You can be a passenger but we advise you to only make short and essential journeys for the first 12 weeks after your operation. We do not recommend using low-seated cars or ones you need to 'climb' into.

If you need to go in a car please ensure that you:

- Sit in the front passenger seat.
- Have the seat as far back as it will go to give you ample leg room.
- Recline the seat back slightly.
- Have a cushion or two on the seat to make it higher, level and supportive.

Getting in

1. Stand with your back to the side of the car
2. Hold on to the seat with your right hand and the frame of the car with your left hand.
3. Extend your operated leg out in front of you and lower yourself slowly on to the seat.
4. Use your un-operated leg and hands to move backwards into the seat, keep your trunk upright – do not lean forwards.
5. Lean backwards slightly and begin to pivot on your bottom and slowly step your legs into the car keeping your operated leg as straight as you can.
6. Once your legs are in the car you can move yourself into your normal seated position but must remain slightly reclined for the duration of the journey.

Getting out

1. Support yourself with your hands either side of you on the seat and pivot on your bottom whilst lifting your legs out of the car door.
2. Once your legs are out of the door, bring your bottom to the edge of the seat keeping your operated leg straight.
3. Place your left hand on the door frame and your right hand on the seat.
4. Push/pull yourself into a standing position.
5. Upon standing bring your operated leg in line with your body.

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Other activities

You can continue with light domestic tasks such as cooking and laundry provided that you follow the advice about not bending, crossing or twisting your legs.

Please remember:

- **DO NOT bend over to reach items in low cupboards or on the floor** – consider placing items on worktops or higher shelves to prevent the need to do this. Use a helping hand if you do drop anything.
- **DO NOT stand for long periods of time** – try to spread household tasks throughout the day and allow plenty of time for rest.
- **DO NOT do any heavy housework** - e.g. carrying heavy shopping, vacuuming until you are advised otherwise.

Follow-up

When you are discharged from hospital you will be given an appointment to have your sutures or clips removed either by your district nurse or in the hospital, and will be given a follow-up appointment to see the consultant 6 weeks after your operation. In the meantime if you experience any problems you should contact your GP for advice, or in an emergency go to A&E.

Symptoms to report

If you have any of the following symptoms you should seek medical advice as soon as possible:

Signs of infection:

- Increase in swelling and redness at the incision site.
- Change in the colour of the wound.
- Discharge of clear or pus-like fluid from the wound.
- Increased pain in the knee.
- Temperature higher than 38°C.

Signs of deep vein thrombosis (DVT)

- Swelling in the thigh, calf or ankle that does not go down with elevation of the leg
- Pain, tenderness and heat in the calf muscle.

Please note blood clots can form in either leg.

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Signs of pulmonary embolus (PE)

If a blood clot becomes lodged in the lungs this is a pulmonary embolism (PE), which is serious. A PE is an EMERGENCY. If you have any of the symptoms of a PE call 999:

- Sudden chest pain
- Difficulty and/or rapid breathing
- Shortness of breath
- Sweating
- Confusion

Contact details

If you have any questions or concerns you can contact the hospital on one of the following numbers:

Elective Orthopaedic Ward Lyndon 3

0121 507 3919

To contact one of the orthopaedic surgical care practitioners or a physiotherapist please contact the main hospital switchboard and ask for them. They are available Monday – Friday, 9am – 4pm.

Hospital Switchboard

0121 554 3801

Bleep numbers

Orthopaedic Surgical Care Practitioners:

Louise Pickering: 5111

Jenny Durston: 5326

Martin Beard: 5433

Derek Norman: 5436

Orthopaedic Physiotherapist: 5838

Orthopaedic Occupational Therapist: 6770

Hospital address

Sandwell General Hospital

Lyndon

West Bromwich

West Midlands

B71 4HJ

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Further information

Arthritis Research UK

www.arthritisresearchuk.org

NHS Choices

www.nhs.uk/conditions/osteoarthritis

Sandwell and West Birmingham Hospitals NHS Trust

www.swbh.nhs.uk

Sources used for the information in this leaflet

If you would like a list of the sources used for the information in this leaflet please contact the Patient Information Officer on 0121 507 5420, or email swb-tr.swbh.gm-patient-information@nhs.net.

If you would like to suggest any amendments or improvements to this leaflet please contact the communications department on 0121 507 5420 or email: swb-tr.swbh.gm-patient-information@nhs.net



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