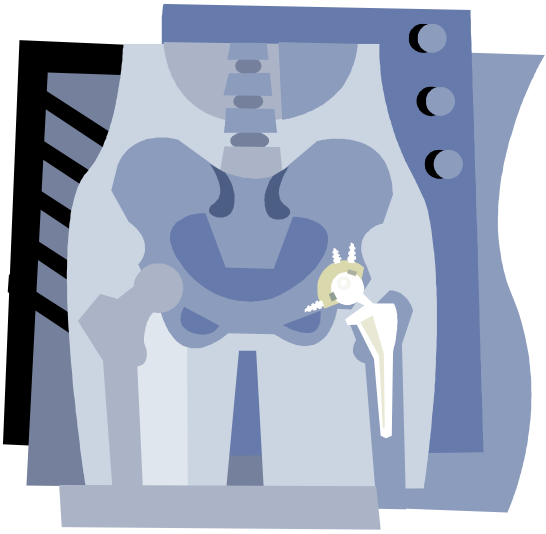
Health
Northern NSW
Local Health District

Grafton Base Hospital

TOTAL HIP REPLACEMENT



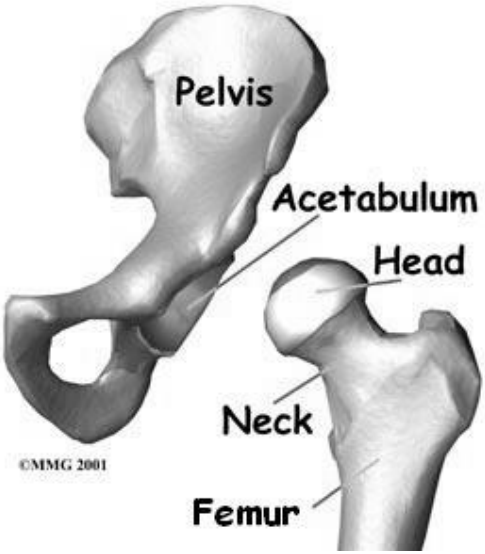
Handbook for total hip replacement

THE HIP

The hip joint is a "Ball and Socket" joint, formed by the head of the femur (ball) fitting snugly into the acetabulum (socket) of the pelvis. It relies on strong muscles and ligaments of the buttocks, thigh and pelvis for support and stability.

Free movement occurs in flexion (bending) and extension (straightening) as well as abduction/adduction (sideways movement), and rotation or twisting.

The synovial membrane provides the lubrication for the joint's articular cartilage, which normally lines the joint surfaces. This cartilage allows smooth pain free movement of the hip joint.



The main structures of a normal hip joint.

WHAT IS JOINT DAMAGE ?

Damage can occur in a hip joint for a variety of reasons. It may be due to abnormal development, injuries (including sport injuries) fractures, wear & tear or some disease process that produces joint damage, eg. rheumatoid or osteoarthritis.

OSTEOARTHRITIS is a degenerative joint disease affecting the cartilage lining at the ends of the bones and the underlying bone. Over time the cartilage deteriorates and becomes rough. Smooth movement of the joint is affected; the bone surfaces may actually touch, causing a grinding feeling.

RHEUMATOID ARTHRITIS is a chronic inflammatory, systemic disease. It primarily attacks the synovial linings of the joints, causing inflammation and swelling. As a result of the arthritic process, the linings become thickened and the fluid that is normally secreted in the joint will contain enzymes, which actually break down bone cartilage and tendons.

TRAUMA will also cause the development of arthritis. Damage to ligaments or joint surfaces may cause the joint to become unstable and subject to increased and abnormal stresses which causes further deterioration of the articular cartilage.

Poor alignment of bones following fractures may lead to abnormal wear patterns, resulting in premature joint break down.

Osteonecrosis can occur following a fracture of the neck of femur or for other reasons. In some cases the blood supply to the head of femur (the ball) can be damaged, resulting in the bone crumbling away.

The end result of all of the above is increasing pain, stiffness with decreased joint movement.

REASONS FOR SURGERY

A large number of people develop hip problems to some degree. The majority can be successfully managed without surgical intervention by physiotherapy, weight control, orthotics, hydrotherapy, modifying leisure / sporting activities and medication.

Joint Replacement Surgery is only for those people with severely damaged joints that cannot be successfully dealt with by such methods.

Surgery is performed to:

- **reduce pain**
- improve movement and function

In other words, to improve the quality of your life.

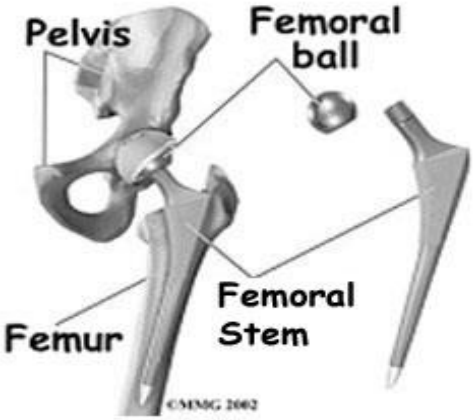
WHAT IS A TOTAL HIP REPLACEMENT ?

The Total Hip Replacement consists of 2 parts;
- A ball with a stem which fits into the femur (thigh bone),
- An Acetabulum (the socket) which fits into the pelvic bone

Various materials can be used eg metal, ceramic and polyethylene. These components are secured to the bones in two ways

1. Bone Cement (like a strong glue) with instant fixation.
2. New bone growth into the metal with or without bone screws, which takes a number of weeks to gain its strength.

There are numerous models and makes of these components. The surgeon makes a choice depending on their assessment of the individual needs.



The components of a Total Hip Replacement

EXPECTED OUTCOMES

More than 90% of people experience good to excellent results following a Total Hip Replacement with regard to pain relief and improved function.

This allows for easier walking, sitting, driving and coping with all activities of daily living with less difficulty.

In a small percentage of people problems occur that require further intervention. For example:

- **Dislocation**: This can occur when the Hip Precautions are not adhered to. It can result in further surgery in less than 1%.

- **Infection** (less than 1%). This will need to be treated with antibiotics and occasionally may need further surgery. There is a life long risk if infection spreads in the blood.

- **Loosening** of one of the components over a period of time. Revision surgery is possible in most cases, with the implantation of a new component, however this does mean another major surgical procedure but the risk of revision surgery is higher and the results may not be so predictable.

- **Wear & tear**. Implanted hip prostheses may wear out and require revisions or replacements at a later date.

- **The operated leg** may be slightly longer, and this can cause problems with gait.

- **Nerve** injury during hip surgery is uncommon. An injured nerve usually improves over time and may recover completely. Permanent nerve damage may cause muscle weakness, for example, foot drop and pain and numbness in the leg.

- **Heterotrophic bone** (extra bone) formation around the joint particularly in revision Joint Replacements can lead to a very stiff hip.

- **A hip replacement** is major surgery and as with all surgical procedures it does have risks such as stroke, heart attack, pneumonia, blood clots and in the rarest of occasions, death.

- **Deep vein thrombosis** (DVT) may occur when blood becomes sluggish within the veins of the lower limbs, leading to clot formation (thrombosis).This risk for DVT can be reduced by lower limb exercises, early mobilisation, anti-thrombolytic support stockings, or anti-coagulant medication (blood thinning medication).

With current technology and design, the average life of primary implants is approximately 15 to 20 years or even much more but one of the risks of the surgery is early failure.

POSITIVE APPROACH

Preparing mentally for surgery is as important as preparing physically. We are fortunate to live in an age where Joint Replacement is possible.

The improved lifestyle after Joint Replacement can be well worth the risks and stress of surgery. The Rehabilitation phase following the surgery will take some time and effort on your part, but this should be preferable to an arthritic painful joint that is likely to continue to deteriorate over time.

The staff at Grafton Base Hospital are committed to providing you with the necessary care and support to enable you to achieve the best possible result from your new joint.

PRE-ADMISSION CLINIC

You will be required to attend a pre-admission clinic prior to your hospital admission, to assist in preparation for your surgery and discharge.

When you have been allocated a date for your surgery, the hospital will contact you with details of your pre-admission clinic appointment.

The clinic is held in the Surgical Services Unit at Grafton Base Hospital, in the same area where you booked in for surgery.

At the clinic you will be seen by a nurse and the Anaesthetist.

You will be asked questions about your health as well as having the required cardiograph (ECG), X-rays, swabs urine and blood tests arranged.

The Anaesthetist will assess your overall health and aims to ensure you will be fit enough to undergo this major surgery. He will discuss the type of anaesthetic most appropriate for you and what medications you may need to cease before surgery, for example blood thinners, aspirin, any diabetic and anti-inflammatory medications.

The Anaesthetist will also discuss the different options for the surgery regarding spinal or general anaesthetic. With your safety and post-operative comfort in mind we would normally strongly recommend a spinal where possible. A spinal is a bit safer and offers a much better more comfortable and rapid recovery than a general for at least the first 24 hours post op. Some people are put off the idea of a spinal anaesthetic due to worries about having to listen to the surgery. In most cases that isn't an issue- the Anaesthetist can still make a patient with a spinal block snooze through the surgery.

There will be an opportunity to discuss the type of anaesthetic and any other questions you may have regarding your surgery and anaesthetic at the pre-assessment clinic. It is a good idea to make notes at home to bring in so you don't forget any questions to ask.

It is a good idea to bring a member of your family or a friend to the clinic as a lot of information is given to you on this day.

The occupational therapist will contact you to discuss your home environment and discharge plans with you. This is to ensure you have adequate social support and facilities to manage as independently and safely as possible when discharged.

A physiotherapist may also contact you to plan the most appropriate walking aid, with the aim of trialling this prior to surgery. You will also learn the appropriate exercises so you can start practising early.

LEVEL ONE

You will be staying in the purpose built orthopaedic rooms on Level One.

Visiting hours are between 10.00a.m. and 8.00p.m. with a rest period between 1.00p.m. and 3.00p.m. each day. Please limit visitors in the first 24 hours after surgery to close family and friends for your own well being and recovery.

Friends and family may phone the ward on 66418450 at any time for information and calls will be put through to patients during the following hours to reduce interruptions:

10.00a.m.	-	12.00noon
3.00p.m.	-	5.00p.m.
7.00p.m.	-	8.00p.m.

YOUR CHEST

If you develop a cough, cold or chest infection within the week before the operation, the Anaesthetist will delay your surgery. Please phone the Day Procedure Unit on 6641 8351 if this occurs.

SMOKING AND ALCOHOL

Smoking should cease as soon as possible, but at least two weeks before your anaesthetic. The hospital can offer QUIT packs to help you with this. Please enquire at your pre-admission appointment.

Smoking is not permitted in the hospital or its grounds. Should patients wish to smoke they should do so outside the hospital grounds, and will be required to sign a form.

Alcohol should not be consumed for at least 24 hours before your anaesthetic.

SKIN CARE

Please protect yourself from scratches, infections, insect bites, sunburn etc… in the weeks leading up to the surgery, as you may not be operated on if there are any skin problems, due to the risk of infection.

Please let the Day Procedure staff know if you have any scratches or wounds prior to admission by phoning 66418351.

DO NOT BRING

- Valuables and large sums of money. The hospital is not responsible for their loss.

WHAT TO BRING

- Medicare card, Private Health Insurance;
- Pension, repatriation or Health Care Card;
- All relevant x-rays;
- All your regular medications in their original packaging or Webster pack;
- Personal toiletries, night garments, covered shoes with non-slip soles. Make sure the shoes are not tight as your feet may swell a little. Loose fitting day clothes e.g. shorts and T-shirt.
- Planned walking aid e.g. crutches.

ADMISSION

The Day Procedure Unit will phone you the working day prior to your procedure for your admission time and fasting instructions and advise you when to take the Gabapentin tablet that was given to you in pre anaesthetic clinic

FASTING

You will be given a fasting time when The Day Procedure Unit staff phone you. Fasting means nothing to eat or drink; including water, gum and lollies. You may be asked to have your usual medication prior to admission; take this with a sip of water only. Diabetics will be given instructions at the pre-admission clinic regarding your medication.

BEFORE YOUR OPERATION

The nurse at the Pre-Anaesthetic Clinic will give you three surgical sponges (pre-operative body sponge). Two nights before you go to theatre use one sponge as directed on the pack. Use the second sponge the night before surgery. Be careful not to slip if shower becomes soapy.

DAY OF OPERATION

Shower again the day of surgery and use the third sponge following instructions. The body should be rinsed well and dried using a clean towel. Clean clothes and shoes should then be worn.

DO NOT shave, wax or clip your hair at home before admission.

DO NOT use any powder, deodorant, make-up, nail polish, perfume or jewellery.

Arrive at Admissions in the Surgical Services Unit at the time instructed. Your hip area will be shaved and prepared for surgery. You will also need to give a sample of urine of admission, so avoid emptying bladder immediately before admission.

SURGERY

Your operation will last approximately 2-3 hours and you will wake up in the recovery room. You will stay there until you have adequately recovered from the anaesthetic and your pain is controlled.

POST-OPERATIVELY (Day 0)

You will have an oxygen mask or nasal prongs and an intravenous infusion (drip) in your arm to give you fluid, antibiotics, pain relievers and blood if required. A urinary catheter may be required.

There may be a surgical drain from your wound to remove any excess blood and fluid from the operation site.

A nurse will be checking you regularly for bleeding, swelling, movement, sensation and pain, as well as your vital signs.

Once your condition is stable you will be transferred to the Orthopaedic Ward –Level 1.

Good pain control is most important after your surgery. A "push through the pain" approach isn't recommended. Please speak up if you have excessive pain so that we can increase or change your medications to get you comfortable. Some pain or discomfort is inevitable but the recovery should not be excessively painful.

Your vital signs will continue to be monitored. The frequency of observation will decrease as your condition improves.

You will have a device on your legs that will gently squeeze to help prevent deep vein thrombosis (blood clot).

THE DAYS AFTER YOUR OPERATION

- The nurse and physio will remind you of your hip precautions
- If diabetic you may have adjustments made to your medications to allow strict control of your sugar levels
- If you have a drain or catheter it will be removed.
- You will have a blood test to determine if you may need a blood transfusion.

- An x-ray is done 24 hours post op if not already done in theatre, to check the alignment of the components.
- You will be assisted out of bed by the physiotherapist and the nurse the morning after your operation.
- You will become more mobile with time and practise.
- You will have medication to help you go to the toilet. Pain relief medication and decreased mobility can cause constipation. **(It is very important to keep your bowels regular).**

The physiotherapist will give instructions about the ongoing exercises for your new hip (see page 24).

Exercises are your responsibility and you can attend to most of them by yourself, as instructed by the physiotherapist. It can be a good idea to try to time the "PRN" pain relief that you can ask for as needed so that it kicks in before Physio sessions. (Do not compromise your physio because you have pain and you don't want the medication). The longer you leave the physio the harder it is.

It is also important to regularly perform **deep breathing and foot/ankle exercises**. The nursing staff will remind you, but you should use your own initiative. These exercises will help to prevent respiratory problems in your lungs and clots in your legs. (see page 27)

Later your intravenous line (drip) will be removed if you are tolerating food and fluid and your pain can be managed with tablets.

You will be encouraged to be more independent. You will be feeling less pain and more motivated to participate in your own care.

You will be educated on administering your own Clexane injection if the Doctor wants you to have this medicine. This is used to prevent clots. You will be prescribed this on discharge for up to four weeks after the operation.

You will be progressed onto your pre-determined walking aid eg. Crutches, 4 wheeled walker or pickup frame under the guidance of your physiotherapist.

You will be ready for discharge when :

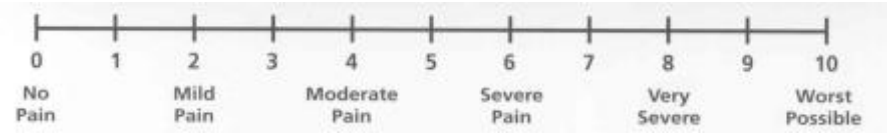
1. The wound is ok.
2. Pain is controlled by tablets.
3. Independent in/out of bed and to the toilet/shower.
4. Managing basic leg exercises.
5. Understand the Hip Dislocation Precautions (see page 23)
6. Independent with your walking aid.
7. Managed stairs safely.
8. You can administer your clexane injection independently if needed.
9. Occupational therapy and physiotherapy are content with your overall progress.
10. It is safe and sensible to go home.

The typical stay in hospital after hip replacement surgery is getting less and less. Our first version of this book said 5 days was average but now some people are able to go home much earlier than that. Many people are ok to go home after 2 or 3 days or occasionally even 24 hrs. Don't be disappointed if you need longer! If you are keen to go home early it is important to have someone at home with you.

MANAGING YOUR PAIN & NAUSEA

MEASURING PAIN.

GBH uses the Verbal Numerical Score (VNS) to measure pain. We ask you to rate your pain on a scale of 0-10. This assists us in working out what we need to give you to manage your pain. 0 represents no pain, 5 is moderate pain, and 10 represents the worst pain you have ever had or could ever imagine. Please let the staff know if your pain is not controlled. It is not always possible to totally relieve pain but we aim to make you as comfortable as possible. DO NOT let your pain get out of control. We advise that you ask the nurse for pain relief if you feel that your pain is 4 or greater on the pain scale.



It is important to achieve good pain relief in order to enable you to perform your exercises effectively, to improve your ability to rest and to speed up your recovery and discharge.

PAIN CONTROL.

Pain control options include:

- **Get off to a good start.**

  It is much easier to keep pain levels comfortable if you get off to a good start. The key decision that a patient can make that makes a difference to pain levels is to choose to have the surgery done under spinal rather than general anaesthetic. Spinals are a bit safer and offer a quicker and more comfortable recovery. Some patients are worried about listening to the operation but the Anaesthetist can still make you snooze with a spinal block. Hip replacement surgery isn't nearly so sore as it used to be and one of the things that has contributed to that is increased use of spinal anaesthetics.

- **Oral medications.** For most patients especially those that had a spinal anaesthetic, pain will be able to be controlled with some tablets. These may be given with or without injections; depending on the type of pain you are experiencing. Multimodal analgesia refers to different medications given at the same time which can include injections the doctor puts in at the time of surgery. The aim of this is to target different pain "pathways" in the body to more effectively manage

your pain. It is extremely important to take regular pain medication including paracetamol.

- **Patient Controlled Analgesia (PCA).** A machine, which delivers pain medication through your intravenous drip whenever you (the patient) press the control button. This allows you to have control over your own pain. Refer to PCA leaflet given to you at the pre-admission clinic. PCAs can cause nausea and we are using them less. They are only rarely necessary now, and very very rarely necessary for patients who had a spinal anaesthetic.

- **Regional Nerve Blockade.** Prior to surgery your anaesthetist may insert a tiny threadlike tube into your leg close to your nerves. Drugs are injected into the tube to numb the area of the body that is to be operated on. These aren't used much currently in Grafton.

- **Norspan Patch** is a patch applied to your arm, that releases a slow continuous dose of pain medication, usually for 7 days. Oral medications can be used to supplement this patch. These aren't used much currently for hip replacement surgery.

- **Epidural.** This is a regional nerve block where a thin plastic tube is inserted between two vertebra into the epidural space. It is currently rarely used after joint replacement surgery in grafton. It is used as a form of anaesthetic during your operation and can be left in

for up to three days to provide pain relief post operatively, allowing good pain relief for your increasing mobility.

NAUSEA

Anaesthetics and pain relieving medications can make you feel nauseated. Effective anti-nausea drugs are available and it is important that you ask for them if you are experiencing nausea.

While it is not important to eat initially, it is important to continue sipping fluids when you are feeling nauseated.

CONSTIPATION

Constipation is often a problem following surgery. This may be due to the use of pain relieving medications, limited movement and a change from your usual eating habits.

Should this be a problem for you, be sure to discuss this with your nurse and/or doctor. Regular medication will be given to you to combat constipation whilst you are in hospital. If you are sent home on pain medication, be sure to ask the nurse if they cause constipation. If so, continue bowel medications for the duration of your pain medication. Various bowel medications are available over the counter or at supermarkets.

REHABILITATION

After your operation the role of the therapist is to prepare you for discharge by helping you achieve independence as safely and as quickly as possible.

You will not be discharged until you are safe and independent with your self care, ie. walking short distances with your crutches or frame, get in and out of bed etc. However, you will need assistance at home with tasks such as cooking, cleaning & shopping.

You will have a review with your surgeon at around 6 weeks after surgery. At this point you may be allowed to drive again.

Whilst you will generally be independent by 6 weeks, hip replacements continue to regain strength and movement beyond 12 months. So be prepared to continue to work on improving your outcomes over this extended timeframe.

HIP DISLOCATION PRECAUTIONS:

Observe these precautions for **three months or more** following your surgery.

Due to the type of surgery you have had, there remains a real risk of dislocating your hip in certain positions. Here are some examples of incorrect and correct ways of performing these tasks.

The main movements to avoid are:

1. **Bending past 90 degrees**

It is especially important to avoid a 90 degree bend at the hip in combination with your leg twisted or moved inwards across your centre.

For example, putting a shoe on by reaching outside your knee would cause a combination of movements that can "pop" the hip out. Always remember to **put your shoes on from inside your knees** as shown in the diagram on the following page.

Common times for dislocation are sitting in low chairs and on low toilets. So REMEMBER to use the correct equipment. (Eg higher chair, Over Toilet Aid.)

Long term combinations of these movements should be avoided but especially in the first three months as the risk of dislocation is higher early.

HIP PRECAUTIONS AFTER HIP REPLACEMENT

Safe way to put on shoe ✓

Unsafe way to put shoe on ✗✗

Safe way to stand from a low chair ✓

Unsafe way to get out of chair ✗✗

HIP PRECAUTIONS AFTER HIP REPLACEMENT

Alternative to put on shoe/socks ✓

AVOID TWISTING or TURNING ✗
AWAY from operated leg

To pick up items off the floor ✓

AVOID BENDING down to the floor ✗

PHYSIOTHERAPY EXERCISES

These exercises are designed to provide a guide to the type of rehabilitation that you will need to do before surgery (as preparation), while you are in hospital, and also when discharged home.

The exercises will help prepare your ligaments and muscles for the new joint, as well as improve mobility and strength after surgery. They should only be done within limits of pain and if you have any concerns or queries, contact your physiotherapist immediately.

Successful patients often report this is one of the most important aspects, which can improve your surgery's result.

After you are discharged, you will have an appointment with your local hospital physiotherapist to monitor your progress over the following weeks until the 6-week post-op appointment with your surgeon. Further appointments will be arranged as needed, or you may attend a hydrotherapy program.

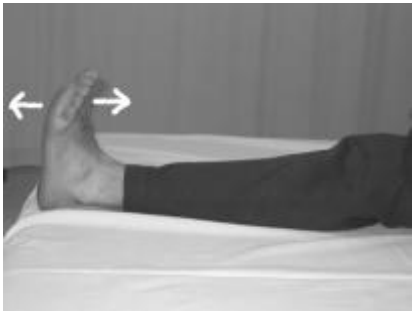
Our aim is to progress your program towards the best possible walking style you can achieve, i.e. no limping!
If you are using a walking aid, try to remember your instructions at all times.

It is much better to walk slowly in the correct pattern, than to rush along, limping! (see the following crutches guide).

EXERCISES:

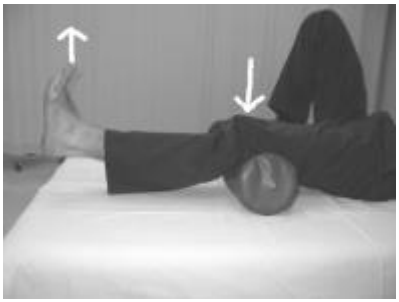
These exercises should be practiced prior to surgery.

1. Ankle exercises, lying down a) move toes/foot up and down



b) slowly rotate foot/ankle in a circle, clockwise and anti clockwise

2. Buttock exercises, lying down squeeze buttock muscles together. Hold for 5 seconds, relax for 5 seconds.



3. Inner Range Quads

With your knee bent over a roll, pull your toes back first, push your knee into the roll as you lift the foot up and down.

4. Knee bending
a) Lying down - Slowly slide heel towards your buttocks and back again

4.Knee Bending
(b) Standing. Hold onto something secure, squeeze buttocks, and bend operated leg .

5. Hip Extension. Hold onto something secure, squeeze buttocks, and take operated leg behind you, careful not to lean forwards at the hips.

6. Hip Abduction. Hold onto something secure, squeeze buttocks, and take the operated leg out to the side without sidebending at the waist.

7. Hip and Knee Flexion.
Hold onto something secure, lift the operated knee up **careful not to bend past 90 degrees.**

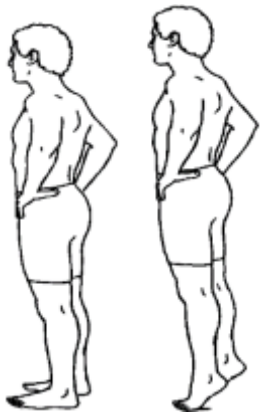
8. Bridges.

Slowly raise buttocks from floor, keeping stomach tight. Repeat x 10 in-a-row.

9. Sit-to-stand.
Sit on edge of chair, feet flat on floor. Stand upright, squeezing buttocks muscles and extending knees fully. Repeat x 10 in-a-row.

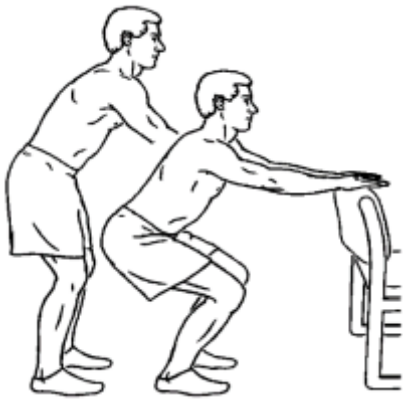
10. Heel Raise.

Rise on balls of feet. Repeat x 10 in-a-row.



11. Squats.

Keeping feet flat on floor, shoulder width apart, squat as low as is comfortable. Squeeze buttocks muscles as you stand back up. Use support as necessary. Repeat x 10 in-a-row.



12. Deep breathing and coughing exercises.

After surgery it is most important to do deep breathing and, coughing exercises to prevent congestion and collapse of your lungs.

The Active Cycle of Breathing Technique.

This technique should be practised at home prior to surgery. It is a proven way of improving your lung function, and will hasten your lungs to recover from the anaesthetic.

1. Take a deep, slow breath in, hold it for 3 seconds, then quietly breathe out through your mouth. **Repeat** another 3-4 times.
2. Continue normal relaxed breathing for 1 minute.
3. Repeat step 1, taking 4-5 deep slow breaths.
4. Take a medium sized breath in and do a huff, by opening your mouth wide and forcing the air out quickly. **Repeat 3 times.** To do a huff, imagine that you are holding a mirror in your hand, and you want to fog it up.
5. Continue normal breathing for 1 minute.

Repeat this cycle until huff becomes dry.

Do this cycle at least once every hour you are awake. Your physiotherapist may prescribe further exercises for you for the long-term maintenance and development of your hip, as you are getting ready for discharge. These will be tailor made for you depending on your individual needs. It is important that you attend the physiotherapy department after your discharge from hospital.

INSTRUCTIONS FOR USE OF CRUTCHES

1. ADJUSTING THE CRUTCHES

- The height of the crutches should be adjusted so there is a 3-finger gap between the top of the crutch and the armpit (adjust using lower two bolts)
- The position of the handle is adjusted to a level where the elbow is slightly bent.

2. USING THE CRUTCHES

- Check that all fittings are tight and rubber stoppers are not worn.
- The weight of the body is taken through the hands, not the armpits

Technique:

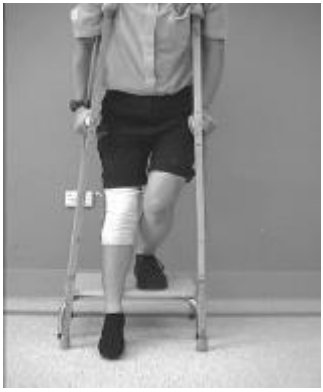
Put the crutches slightly in front of you; support your body weight by **pushing through your hands,** and step with the operated leg **between** the crutches. Then step through with the good leg. Do not jump.

Never press the crutches into your armpit as this can damage the nerves and blood vessels that supply your arm and hand. Take as much weight as you can comfortably. Try to walk with a normal gait, landing on your heel and rolling onto your toes. The physiotherapist will have taught you this pre-operatively.

Stairs/Steps: One step at a time

UP: The good leg goes first, followed by the operated leg and the crutches.

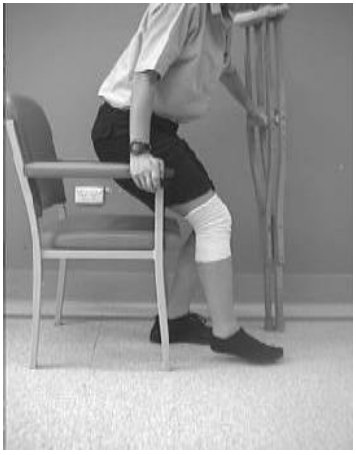
DOWN:
The crutches go first, with the operated leg. Make sure you are supported well on the crutches **before** stepping down with the good leg.

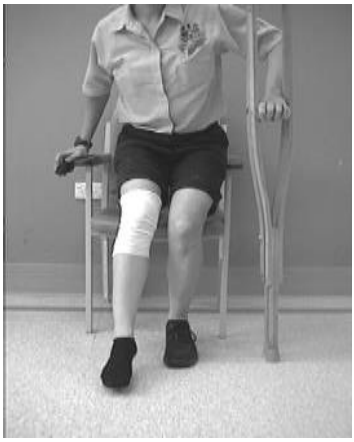


Sitting:

Getting into and out of a chair:

- Hold both the crutches with one hand on the hand grips. The other hand is placed on the arm of the chair or bed.
- To stand put your weight through your good leg and your arms.
- To sit, with one hand find the armrest, put your weight through your good leg and your arms and control the movement- don't plonk.



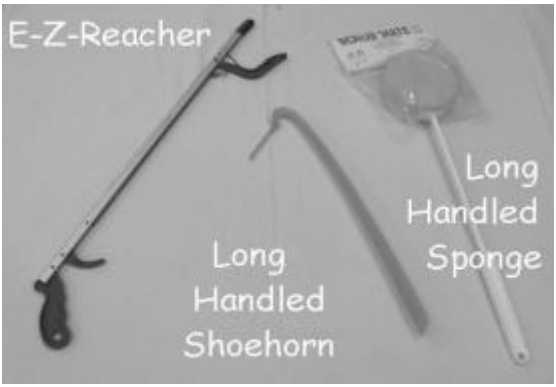


Conditions Of Use:

- Regularly check and tighten the screws on the crutches.
- The user accepts responsibility for checking the crutches periodically for signs of wear, and returning any faulty equipment to your place of purchase.

- The time spent using your walking aid will be determined by the type of surgery (eg un/cemented) and your progress in terms of strength and flexibility. Your surgeon and physiotherapist will monitor this.

Aides for Activities of Daily Living



DAILY ACTIVITIES

You will meet your occupational therapist (OT) pre-operatively. The occupational therapist is a trained professional in rehabilitation who will work with you to ensure that you will be able to return to your daily routine as independently and safely as possible.

Sitting

Ensure that each chair you sit on is an appropriate height and has adequate arm support. If your chair is too low, it needs to be raised up from underneath. Do not sit on a pillow to increase the height.

When seated your hips must always be higher than your knees, you must keep your knees apart and remember NOT to cross your legs. Try not to sit in the same position for more than 30 to 40 minutes at a time.

When getting in and out of the chair you can use the arm rests as an anchor to guide and support you down or to push off. Remember not to lean forward when sitting down or getting up and to keep your operated leg forward when standing.

Dressing

Wear loose, comfortable clothing. Try to wear sturdy, slip-on shoes with good grip and avoid thongs, loose slippers and any shoes that require fastening e.g. laces or buckles. It is recommended that you sit whilst dressing. Dress your operated leg first and undress it last. Avoid bending or twisting by using long-handled equipment including an ezy-reacher, long handled shoe horn or a sock/stocking gutter. Wear your compression stockings as recommended by your doctor.

Showering

It is advisable that you sit whilst showering. DO NOT use taps or soap holders for support whilst in the shower! Your OT (occupational therapist) will determine the most appropriate equipment for your needs from varying designs of bath boards and shower chairs and will loan you any required equipment for a period of 8 weeks. If you require equipment long-term or any rails in your shower, your OT will follow this up for you.

To avoid bending to pick up any dropped soap, use a "soap-on-a-rope" or keep your soap inside a stocking tied to the taps. You can also use aids such as a long-handled sponge or toe-washer/dryer to help you to clean your feet and lower legs without having to bend over.

Going to the toilet

Most toilet seats are too low. To raise the height or your toilet and to give you support to raise yourself off the toilet, the OT can supply you with an over toilet aid with a raised seat and armrests. If required, the installation of a grab rail near the toilet may be considered long term. Further, once you are finished using the toilet, it is important that you stand up and turn your whole body around to face the toilet to flush in order to avoid any twisting movements.

Your bed

When sitting on your bed, your hips must be higher than your knees. For this, you may need to raise the height of your bed. An extra mattress can be added to your bed or your OT can provide blocks to place underneath the legs of your bed. It is also important to ensure that you have adequate circulation space around your bed to manoeuvre yourself and any walking aid.

Positioning in bed

You should get out of bed on the side of your operated hip, so it may be easier to lie on the side of the bed that allows your operated hip to be on the outside. You should lie on your back initially, with a pillow between your legs to keep them in the correct position. If you lay on your side, you must not lie on your un-operated hip as this encourages your operated hip to rotate inwards. Additionally, try to

remember not to cross your legs whilst sleeping. You can use a long-handled ezy-reacher to pull up your sheets and blankets.

Sexual Activity

Sexual activity, just like other activities that you do, will require some modifications after surgery. The soft tissues around your new hip will take approximately 6 weeks to heal. You and your partner may resume sexual intercourse after the wound has completely healed. You should make sure that you are comfortable and avoid any positions that cause pain. A less active role in a passive position (i.e. on your back) is advised. It is important to maintain all hip precautions to prevent the dislocation of your new hip. Resumption of sexual activity may be discussed further with your doctor or occupational therapist.

Driving

It is the doctor's recommendation that you do not drive for 6 weeks following your total hip replacement operation. This applies to both automatic and manual cars. You should follow this up with your doctor at your 6 week appointment.

Getting in and out of the car

Get into the car from street level, not from a curb or doorstep. Always sit in the front seat of the car with the seat pushed back as far as it goes with the backrest at an

approximate 45 degree backward tilt, adjusted as required.

Back up to the car door with your walking aid until you can feel the door frame touch the back of your legs. Lower yourself onto the seat, holding onto the car handy-bar if available. Reach back and hold onto the car seat with your left hand for guidance. Shuffle your bottom back toward the driver's seat, ensuring your upper body is leaning backwards slightly. Swing both of your legs into the car (you may need assistance), keeping your feet separate and your operated hip as straight as possible. Straighten the backrest to a comfortable position, buckle up and you are on your way!

Complete the process in reverse to get out of the car. You should practice this before your operation so that you are comfortable at time of discharge.

Catching the bus

Get into the bus one step at a time, good leg first. Get off the bus one step at a time, operated leg first. This also goes for climbing stairs. This may help you to remember which leg to step with:

"*The good leg goes to heaven (step up)*
The bad (operated) leg goes to hell (step down)"

Ask the driver to wait until you are seated. Choose an aisle seat with your operated leg on the aisle side. Make use of the handles on top of the bus seats for support.

Domestic activities

Handy hints

- Resume activities slowly and give your body time to recover.
- Plan to do a small number of tasks each day, rather than all in one day! Take frequent rests.
- Where possible sit down to complete activities (maintaining hip precautions)
- Store commonly used items e.g. personal hygiene items, kitchen foods and appliances at an easily accessible level (table top height).
- Plan to do activities at waist height. e.g. using a laundry trolley, ironing board etc.
- Use resources at home e.g. electrical equipment and family members.

In general, when doing things in your home such as cooking and cleaning, avoid the following:

- Bending and twisting movements, especially when weight bearing e.g. climbing stairs.
- Lifting, pulling or pushing heavy objects.
- Low surfaces e.g. chairs, toilets, baths.
- Activities that involve stop-start movements and jolting movements.
- Putting on excessive weight. Keep in mind that extra weight means additional stress on your hip.

Recreational Activities

We all have different ways of spending our leisure time. Discussed below are some specific activities, which may or may not apply to you.

Gardening

- Do a little at a time.
- Use long handled tools/implements.
- Complete whilst seated in an appropriate chair.
- Be mindful not to bend down or twist your body.

Swimming

- May be resumed as soon as the sutures have been removed and the wound is healed, approximately 3 weeks post op.
- Maintain hip precautions especially when entering/leaving pool. Most public pools have lifters which may assist you into/out of the water if required.
- AVOID rough ocean waters or swimming in areas that have uneven footing or the ground is not visible through the water.

Bowls

- Check with your doctor, usually safer after 8-12 weeks following your operation.
- Enquire at your bowling club for a "bowls lifter" which is useful for picking up your ball without bending too far.

In general, low impact sports like fishing, easy walking and slow dancing, are possible approximately 8 to 12 weeks following your operation. Avoid activities that involve impact stress on the joint (such as tennis and badminton), contact sports (such as football and baseball), squash or racquetball, jumping or jogging. Your hip replacement will help you to live a more active life – but you have to look after it!!

FOR QUERIES REGARDING ANY OTHER SPORTS AND ACTIVITIES YOU SHOULD CONSULT YOUR SURGEON

Returning to work

Generally when returning to work following your total hip replacement you should avoid any job that involves a lot of sudden, jarring stresses or ongoing heavy weight load on the joint. Examples of unsuitable occupations would include labouring, heavy lifting and digging.

Your doctor or OT will discuss individualised options with you as every person's work roles vary drastically. It may be possible to modify the tasks involved in your current work to reduce the stresses on your hip or to select an alternate, more appropriate occupation.

Community Support Services

If you need assistance at home on discharge from hospital you may be referred to a community support service such as TACs (for people over 70 years being discharged from hospital), Homecare, Feroscare or COMPACS (for people of any age being discharged from hospital).

Equipment

Loans

Your OT will supply any equipment that you will require at home to support your recovery after your operation. You will be advised that all equipment is loaned for a period of 8 weeks. If you need to loan any equipment for longer than 8 weeks, you should contact the Occupational Therapy Department on 6640 2205.

Returns

When returning equipment to the hospital, please take it to the OT Department located in Room 1 in the Annex Building at the rear of the hospital grounds. Fill out an equipment return form located in a plastic box on the door and leave the completed form and equipment beside the OT Department door.

Home Modifications

If required, minor modifications can be arranged through the Clarence Valley Home Modification Service. The CVHMS provides a subsidised service for pensioners. Work can be undertaken for non-pensioners but at full cost. Examples of modifications include the installation of hand held shower hoses, grab rails, hand rails and step ramps, CVHMS can be contacted on 6643 1831.

INFECTION ALERT

Should you develop an infection of the hip replacement (ooze from wound, increased pain, localised swelling, redness or heat around the wound), you must have a wound swab and blood test done such as ESR, FBC and CRP BEFORE any antibiotic therapy is started. It is even more important that an orthopaedic doctor sees the wound before any antibiotics are started (unless you are really sick and its an emergency)

Your GP shouldn't start any antibiotic without letting your surgeon know as you may further surgery for the infection.

It is also important to attend to any cuts or abrasions especially on the leg with the hip replacement.

If you develop any other forms of infection (eg. infected sores, a urinary tract infection, fevers) at any time after your hip replacement, or if you have surgery for any reason (including endoscopic procedures, dental extractions or gum work), contact your GP or surgeon without delay to discuss the possibility of receiving preventative antibiotics. Any delay may cause serious problems or jeopardise the success of your new hip!

NOTE: This is a lifetime consideration

DISCHARGE CHECK LIST

(To be completed prior to discharge)

Discharge Pack	yes	no
Have own medications	yes	no
Requires script	yes	no
Own meds. Returned	yes	no
Own scan/xrays returned	yes	no
Clexane kit	yes	no
Community Services referral	yes	no
Medical Certificate	yes	no

SPECIALIST FOLLOW UP APPOINTMENT IN FRACTURE CLINIC GBH

Patient to make own appoint.	yes	no

……/……../201……..

X-RAY APPOINTMENT WHEN REQUIRED

Referral form given	yes	no
Patient to make own appoint	yes	no
Home assessment conducted	yes	no
Equipment loaned	yes	no

PHYSIOTHERAPY APPOINTMENT WHEN REQUIRED

Referral made by staff	yes	no
Patient to make own appointment	yes	no

COMMUNITY TRANSPORT (if needed)

Certificate of Safety to Travel	yes	no
Time arranged	……. am/pm	

APPOINTMENTS:

Pre op Clinic Date: ……..

Surgery Date: ……..

Follow up dates:

X-ray	Time am/pm	Date / /
Specialist Surgeon	Time am/pm	Date / /
GP	Time am/pm	Date / /
Community Nurse	Time am/pm	Date / /
Physiotherapist	Time am/pm	Date / /
OTHER		
……	Time am/pm	Date / /
……	Time am/pm	Date / /

QUESTIONS FOR THE DOCTOR OR THE PRE ANAESTHETIC CLINIC

This booklet was adapted from the Lismore Base Hospital Hip Replacement Handout.

We hope this booklet has been of help to you. Consult it regularly and discuss any questions with your Surgeon/GP/ Physiotherapist/Occupational Therapist/Nurse and friends prior to the surgery. Information is power. Anxiety comes from the unknown, so find out as many answers to your questions beforehand to reduce this extra stress.

If you have any other queries before, during or after the surgery please contact the

Day Procedure Unit	6641 8351
Level 1	6641 8450
Occupational Therapy Department	6641 8738
Physiotherapy Department	6641 8770

GRAFTON BASE HOSPITAL
REVIEWED 02/17