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Introduction

This booklet has been produced by the orthopaedic team at The Northwest Hospitals NHS Trust in partnership with patients. It is designed to provide information about having a total hip replacement, and what to expect before, during and after the operation.

This advice is provided to help you prepare for surgery and to help your recovery and rehabilitation. It is recommended that you read this booklet thoroughly before your surgery and write down any questions you may have in the back of this booklet. You should bring it with you whenever you come to the hospital.
Introduction
Osteoarthritis - What is it?
Osteoarthritis is a common disease affecting the joints in the body, most commonly the knee and hip. The joint surfaces, which are covered in smooth cartilage, become damaged, gradually thinner and roughen - this produces pain. Eventually, there may be no cartilage left in some areas of the joint. There are other diseases which cause joints to be replaced because of pain, such as rheumatoid arthritis.

Total hip replacement - What is it? – Is it for you?
A total hip replacement is a surgical procedure for replacing the hip joint. This joint is made up of two parts, the hip socket (acetabulum, a cup shaped bone in the pelvis) and the “ball” or head of the thigh bone (femur). During the operation, these two parts are removed and replaced with smooth artificial surfaces. These artificial pieces (the prosthesis) are implanted into healthy portions of the pelvis and thigh bone. The total hip replacement operation is designed to relieve pain, reduce stiffness and improve your ability to walk.

You may benefit from a hip replacement if:
• Severe hip pain limits your everyday activities including walking, going up or down stairs and getting in and out of chairs
• You find it hard to walk any distance without significant pain and you may use a walking aid
• You have moderate or severe hip pain when resting either day or night
• You have a hip deformity
• There is stiffness and an inability to bend and straighten your hip

**Alternatives to surgery**

Prior to offering you surgery to replace your hip your GP and consultant will discuss with you other ways to help to control the pain and restrictions you may have with an arthritic joint.

These may include:-

• Use of painkillers
• Use of anti-inflammatory non-steroidal tablets
• Trying to reduce your weight, if you are overweight
• Physiotherapy

In summary, a total hip replacement is recommended by your consultant when hip pain becomes unbearable and has not responded to any other form of treatment and your lifestyle is greatly restricted.

**What can be expected from a total hip replacement?**

A total hip replacement will provide a large reduction in hip pain in 90% of patients and allows patients to carry out normal activities of daily living. The artificial hip may or may not allow you to return to active sports or heavy labour and you must be guided by your consultant. Taking part in high impact activities and being overweight may speed up the wear and tear process, which could result in the artificial hip loosening and becoming painful. Your consultant will advise you on what level of activity you can do.

**Expected activities after surgery**

The aim of surgery is for you to be able to resume your normal everyday activities without pain including climbing stairs and walking. It is also possible to participate in recreational walking, swimming, golf, driving, light hiking, cycling and ballroom dancing.

Activities not suitable include jogging or running, contact sports, jumping sports and high impact aerobics. The reasons for this are that the hip replacement will wear out more quickly or an injury involving the replacement may be difficult to treat.
What complications (risks) can occur?
This section is not meant to frighten you, but help you to make an informed decision on whether to have a total hip replacement and help you to cope better with any complications that may occur. It is important that you understand that there are possible risks linked with any major operation and total hip replacement is no exception.

Total hip replacement is usually very successful but a small percentage of patients may develop complications. Illness, smoking and obesity may increase the potential for complications. Though uncommon, when these complications occur, they may delay or limit your full recovery.

Infection
The wound on your hip can become inflamed, painful and weep fluid, which may be caused by infection. The majority of wound infections can be treated with a course of antibiotics and often settle down following treatment. Deep wound infections where the new hip is infected may require the new hip to be removed, which can result in a one to three inch leg length shortening.

You can help prevent infections by keeping the wound clean and dry. The wound dressing should normally not be disturbed, and should only be redressed by your nurse. You should also inform your doctor if you develop an infection as you may need antibiotics. The risk of developing an infection following a hip replacement is approximately 1%.

Deep Vein Thrombosis (DVT)
This is the term used when a blood clot develops in the deep veins in the back of your lower leg. When detected the treatment may involve blood thinning injections followed by a course of warfarin tablets. There is about a 4% risk of developing a DVT following surgery.

To help prevent DVT, you will be given foot and ankle exercises to do immediately after your operation. Walking and wearing thrombo-embolic deterrent stockings (TEDS) below the knee for six weeks following surgery also significantly reduces the risk of DVT. Nursing staff will also give you medications to reduce the risk of DVT.

Pulmonary embolism (PE)
This can happen when a part of a blood clot formed in your leg vein breaks off and travels to your lung. The risk of developing a life threatening pulmonary embolism is very low. Treatment is the same as DVT but requires a longer hospital stay.
Foot drop
This occurs when the nerves that control the muscles in the foot become stretched or damaged as a complication of your surgery and can leave you with a weakened or dropped foot. This complication is rare; only occurring in 1:1000 patients.

Difference in leg length
Your consultant will do their very best to ensure your leg length is equal. However if arthritis or wear and tear has destroyed some of your bone this is not always possible and may cause your operated leg to become shorter. This may result in you needing to wear a raised shoe or insole.

Dislocation
This may happen in approximately 2% of patients. It is usually related to crossing your legs, twisting, falling or sitting in a very low chair. You will require an operation to put the hip back into the socket and it may be necessary to protect the hip by wearing a brace. You will need to take certain precautions to avoid dislocation - these are discussed at the Joint School and are described later in the guide (pg 26-36).

Loosening of the prosthesis
Although prosthesis design and materials, as well as surgical technique, have improved, wear of the weight-bearing surface or loosening of the components may still occur between 10-15 years after surgery. Excessive activity or being over-weight may accelerate this wearing process. Loose, painful artificial joints can usually, but not always be replaced. Results of a second operation are not always as good as the first, and the risks of complications are higher.
Pre-admission assessment
It is important that you are assessed prior to your surgery to reduce the risks as much as possible. Most people will have their first assessment for their fitness for surgery with the preoperative nurse in a specialist pre-admission clinic. This will occur on the same day that you see the orthopaedic surgeon. You will also receive a date for your operation at this time.

During your assessment, the pre-operative nurse will ask you about your general health, medical history, previous anaesthetics and if there were any problems. A record will be made of any family history of anaesthetic problems, medicines, pills, inhalers or homeopathic remedies that you use, allergies, smoking, alcohol and whether you have any loose, capped or crowned teeth. You will have investigations, such as blood tests, a heart trace (ECG) and x-rays. This helps your anaesthetist consider any medical problems, which may either affect the risks to yourself or the likelihood of complications from the anaesthetic or surgery.

The pre-operative nurse will give you time to ask questions about the possible complications and give advice and education on your activities following surgery. They will also give you questionnaires to complete, including one for the occupational therapist to identify the need for any equipment or help at home.

Coach
During pre-admission assessment we will ask if you can choose a coach – a friend or family member who will support you throughout your time leading up to surgery, during your time in hospital and once you get home after your operation. Please identify someone who can fulfil this role. It is important you have this support as it will help your rehabilitation.
Joint Replacement School
Before your operation, you and your coach will attend the Joint Replacement School at the hospital. This is a unique and exciting day where you will have the opportunity to learn about your surgery. You will meet other people about to have their hip replaced. The Northwest London Hospitals NHS Trust is one of the few centres in the country to offer this patient focused education. You are encouraged to ask any questions you have however simple you may feel they are.

PLEASE NOTE:
The Joint School is an essential part of your treatment. It is very important that you attend.

The health professionals you may meet at joint school are:

Physiotherapist
The physiotherapist will show you exercises you will need to commence before your operation and give you walking aids to take home and practice walking.

Occupational therapist (OT)
The occupational therapist (OT) will discuss with you how you will manage your daily activities at home. This will include getting washed and dressed, getting on and off the toilet, bed and chair, getting in and out of the bath and kitchen activities.

On the rare occasion, a home visit may be necessary to gather more information on how you will cope at home. If you have any equipment needs, these will be addressed by your OT. Equipment will only be ordered with your consent.
Anaesthetist
Anaesthetists are doctors who are responsible for giving your anaesthetic, controlling your pain and for your wellbeing and safety throughout your surgery. You may not meet an anaesthetist at the Joint Replacement School, but you will learn about the different anaesthetics you can have.

As there are a number of different ways in which you can be anaesthetised, you will learn about the different options. It is important you read the information about your anaesthetic in this booklet, so you have an idea of the preferred anaesthetic used at this hospital. You will meet your anaesthetist on the day of surgery and finalise the type of anaesthetic most appropriate for you and discuss any issues you would like to raise.

Pain nurse
The pain nurse will discuss the importance of pain assessment and the most appropriate methods for treating your pain after your operation.

Surgeon
You may see a surgeon, who will explain in detail, your operation and the risks and benefits to you. You might be asked to give consent for the operation by signing a consent form. This does not mean you have to have the operation, as you can change your mind at any time, even on the day of surgery. If you do decide not to have the surgery however, you must let us know straight away. The surgeon you see may be different from the one you met in clinic and may not be the person performing your operation.

Ward nurse
The nurse will explain what to expect on your arrival at the hospital, things you need to bring with you for your stay and explain how you will go to theatre and return to the ward. They will talk to you about drips and drains you may have in place and x-rays taken after surgery. You will be told about MRSA and the importance of personal cleanliness prior to surgery.

When you come in for your operation, a nurse will escort you to theatre for your planned surgery and care for you following your surgery. The nurse will monitor your progress, check your wounds and care for you until discharge home. On discharge the nurse will ensure that you have all necessary paperwork, dates for further appointments and all medications. Nursing staff will also participate in the supervision and aiding of your mobilisation on the ward.

Pharmacist
The pharmacist will take a complete drug history, including full details of all your prescribed medicines, any medicines you purchase over the counter and any herbal or homeopathic medicines that you take. The pharmacist will review your regular medication and ask you to bring all your medication to hospital when you come in for your operation. The pharmacist will advise you about which of your medicines will need to be temporarily stopped or adjusted and which will need to be continued up to the time of your surgery.
It is most important that you bring all your medicines and a copy of your prescription with you when you come to the Joint Replacement School. They should be in their original containers with their labels.

Your anaesthetic

Anaesthetists are doctors with specialist training who:

• discuss types of anaesthesia with you and find out what you would like, helping you to make choices
• discuss the risks of anaesthesia with you
• agree a plan with you for your anaesthetic and pain control
• are responsible for giving your anaesthetic and for your wellbeing and safety throughout your surgery
• manage any blood transfusions you may need
• plan your care, if needed, in the Intensive Care Unit
• make your experience as calm and pain free as possible

Your anaesthetist will meet you before your operation and will:

• ask you about your health
• discuss with you which types of anaesthetic can be used
• discuss with you the benefits, risks and your preferences
• decide with you which anaesthetic would be best for you
• decide for you, if you would prefer that.

Nothing will happen to you until you understand and agree with what has been planned for you. You have the right to refuse if you do not want the treatment suggested or if you want more information or more time to decide

The choice of anaesthetic depends on

• your operation
• your answers to the questions you have been asked
• your physical condition
• your preferences and the reasons for them
• your anaesthetist’s recommendations for you and the reasons for them
• the equipment, staff and other resources at your hospital

You may have heard that there are several different types of anaesthetic:

• a general anaesthetic
• a spinal anaesthetic
• an epidural anaesthetic
• a nerve block (to help with pain afterwards)
• a combination of anaesthetics.
Types of anaesthetic

**A General Anaesthetic**
A general anaesthetic produces a state of controlled unconsciousness during which you feel nothing.

You will receive:
- anaesthetic drugs (an injection or a gas to breathe)
- strong pain relief drugs (morphine or something similar)
- oxygen to breathe
- sometimes, a drug to relax your muscles.

You will need a breathing tube in your throat whilst you are anaesthetised to make sure that oxygen and anaesthetic gases can move easily into your lungs. If you have been given drugs that relax your muscles, you will not be able to breathe for yourself and a breathing machine (ventilator) will be used. When the operation is finished the anaesthetic is stopped and you regain consciousness.

**Advantages**
You will be unconscious during the operation.

**Disadvantages**
A general anaesthetic **alone** does not provide pain relief after the operation. If given alone, you will need strong pain relieving medicines afterwards which make some people feel quite unwell. Hence it is almost always combined with other forms of anaesthetic to provide better pain relief during and after the operation. Some of the risks and side effects of general anaesthetics are described later in this booklet.

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**Surgical Infiltration**
This is an innovative approach where ‘a cocktail’ of large volumes of local anaesthetic and pain killers are injected in and around the joint by the surgeon at the time your new joint is going in. It is an increasingly popular technique in a large number of hospitals. It is more often combined with general anaesthesia but can also be done with spinal and epidural anaesthesia.

**Advantages:**
Our experience over the past year shows that this technique of anaesthesia i.e. general anaesthesia with surgical infiltration provides excellent pain relief immediately after and the day following the surgery. It reduces the need for strong pain killer injections like morphine and thus reduces side effects like nausea and vomiting.

It allows early mobilisation and physiotherapy in recovery which is a very important step towards rapid recovery.
**Disadvantages:**
In some cases it may not provide adequate pain relief and hence may need to be combined with morphine injection.

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**A spinal anaesthetic**
A measured dose of local anaesthetic is injected near the nerves in your lower back. This can make;
- you go numb from the waist downwards
- you feel no pain, but you remain conscious
- If you prefer, you can also have drugs which make you feel sleepy and relaxed (sedation).

**Advantages – compared to a general anaesthetic**
- There is some evidence that less bleeding may occur during surgery which would reduce your risk of needing a blood transfusion
- You remain in full control of your breathing. You breathe better in the first few hours after the operation
- You do not need so much strong pain relieving medicine in the first few hours after the operation
- You should have less sickness and drowsiness after the operation and may be able to eat and drink sooner.

**Disadvantage**
Some of the risks and side effects of a spinal anaesthetic are described later in this booklet.

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**An epidural anaesthetic**
A small plastic tube (an epidural catheter) is passed through a needle into a place near to the nerves in your back. Through this tube, you receive a measured dose of local anaesthetic and pain relieving drugs. You will experience a reduction of feeling in your lower body.

Although operations can be done with an epidural alone, it is more commonly used for:
- operations expected to be very long, say more than three hours
- operations expected to be particularly painful afterwards.

For these operations, it is often combined with a spinal or a general anaesthetic.

**Advantages**
- It can be topped up with more local anaesthetic, and therefore its effects can be made to last longer than a spinal anaesthetic.
- It can be used to make you comfortable for several days after the operation.

**Disadvantages**
- Not all epidurals are fully effective in relieving pain after the operation. If this happens you will receive additional pain relief.
Some of the risks and side effects of an epidural anaesthetic are described later in this booklet.

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**A nerve block**
This is an injection of local anaesthetic near the nerves which go to your leg. Part of your leg should be numb and pain-free for some hours afterwards. You may also not be able to move it properly during this time.

If you are having a general anaesthetic, this injection may be done before the anaesthetic starts, or it may be done when you are unconscious.

**Advantages**
- You usually need a lighter general anaesthetic and you should be less sick and drowsy afterwards. This is because you should need less strong pain relieving medicines during and after the anaesthetic
- You should be more comfortable for several hours after the operation.

**Disadvantages**
- The numbness and muscle weakness may last for up to 16-24hrs thus delaying mobilisation and physiotherapy
- Rarely there is a risk of damage to the nerves.

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**A combination of anaesthetics**
You can have a spinal or epidural anaesthetic and a general anaesthetic together.
- You gain the benefits of a spinal or epidural anaesthetic but you are unconscious during the operation.
- The general anaesthetic will be ‘lighter’.
- Unpleasant after-effects of the general anaesthetic may be less.

You can have a nerve block with a general anaesthetic, or after a spinal anaesthetic.
You should be more comfortable for some hours after the operation than with a general anaesthetic or spinal anaesthetic alone.

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**Understanding risk**
In modern anaesthesia, serious problems are uncommon. Risk cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years.

**The risk to you as an individual will depend on:**
- whether you have any other illness
- personal factors, such as smoking or being overweight
- surgery which is complicated, long or done in an emergency
People vary in how they interpret words and numbers. This scale is provided to help.

<table>
<thead>
<tr>
<th>Very common</th>
<th>Common</th>
<th>Uncommon</th>
<th>Rare</th>
<th>Very rare</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 10</td>
<td>1 in 100</td>
<td>1 in 1000</td>
<td>1 in 10,000</td>
<td>1 in 100,000</td>
</tr>
</tbody>
</table>

**Side effects and complications**
Below is a list of side effects and complications that may occur following anaesthetic.

RA = This may occur with a regional anaesthetic.
GA = This may occur with a general anaesthetic.

<table>
<thead>
<tr>
<th>Risks</th>
<th>GA</th>
<th>RA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very common and common side effects</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling sick and vomiting after surgery</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sore throat</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dizziness, blurred vision</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Headache</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bladder problems</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Damage to lips or tongue (usually minor)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Itching</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Aches, pains and backache</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pain during injection of drugs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bruising and soreness</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Confusion or memory loss</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Uncommon side effects and complications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest infection</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Muscle pains</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Slow breathing (depressed respiration)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Damage to teeth</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>An existing medical condition getting worse</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Awareness (becoming conscious during your operation)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Rare or very rare complications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damage to the eyes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Heart attack or stroke</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Serious allergy to drugs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nerve damage</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Death</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Equipment failure</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.
Before your operation
You will be asked some questions to check your health before your operation. This may be at a pre-assessment clinic, or it may be by filling in a questionnaire, by talking to the doctors on the ward or by talking to your anaesthetist.

You will be asked about:
- your general health and fitness
- any serious illnesses you have had
- previous anaesthetics and if there were any problems known to you
- whether you know of any family members who have had problems with anaesthetics
- medicines, pills, inhalers or homeopathic remedies that you use
- any allergies that you have
- whether you smoke
- whether you drink alcohol
- whether you have any loose, capped or crowned teeth.

The anaesthetist’s visit
Your anaesthetist will meet you before your operation and he/she will talk to you about which kind of anaesthetic is suitable for you. This is a good time to ask questions and tell the anaesthetist about any worries that you have. You may find it useful to write down any particular concerns before meeting your anaesthetist so that you don’t forget anything.

“This is how we usually do it”
You may find that your anaesthetist and the team of staff looking after you have very regular experience of a certain type of anaesthetic and less experience of others. This would add to the advantages of that technique over others.

Delaying your operation
Unfortunately on rare occasions your anaesthetist may suggest delaying your operation for a few weeks. This may be because he/she thinks that:

- your health could be improved to reduce the risks of the operation or the anaesthetic.
- you need some more tests

It is possible that your anaesthetist will think there are very high risks. You may want time to think about whether to go ahead with the operation. These concerns will also be discussed with your surgeon. It may be necessary in such situations to organise a special ‘high dependency or intensive care unit’ bed for you to keep a closer eye on you in the first few day or days after the operation.
Things to do before your operation

Your coach
During pre-admission assessment we will ask if you can choose a coach – a friend or family member who will support you throughout your time leading up to surgery, during your time in hospital and once you get home after your operation. Involve your coach as much as possible during your time leading up to your operation. They can be invaluable to you in organising your home and helping you with your exercises before your operation.

Exercises
It is important to do the recommended exercises leading up to your planned surgery as this will strengthen your muscles and help in the recovery period.

These exercises will be shown to you at the Joint Replacement School. Having strong and fit muscles speeds your recovery and ultimately improves the outcome of your operation.

Diet
You will recover more quickly from surgery if you are healthy beforehand. Try to eat a healthy diet in the time leading up to your operation. It is quite common to experience constipation following your surgery. A healthy diet will reduce this risk. If you have any concerns about your diet, discuss them with your GP; you can be referred to a dietician if necessary. If you are overweight, it is very important to reduce your weight in preparation for your surgery. This will help to reduce any risks associated with anaesthetic and your new joint will last longer. Remember, it is recommended that a healthy diet includes five portions of fruit and vegetables a day.

Smoking
Smoking cigarettes will compromise healing after any surgery and make you more prone to infection. Smoking also contributes to lung, heart and other medical problems. All of these make recovery much harder. This is because smoking reduces the amount of oxygen being delivered to the tissues, which is vital for the healing process. It is best to try and stop smoking, at least two weeks before surgery and 6 weeks after, to give time for the wound and tissues around the hip to heal.
You can get help and advice on smoking from the NHS Free Smoking Helpline: 0800 022 4 332 - seven days a week, 7am to 11pm.
Prepare your home
Remember, when you first go home after your operation you will not be fully mobile and may have some restrictions on what you are able to do. Think about the things you normally do and make some adaptations. For instance, if you keep your mugs, plates, etc. in a low cupboard, consider moving them to a more accessible place for a short while after your operation. If you have to cook for yourself, consider making or buying some ready meals that are easy to prepare when you come home. It is also wise to be up to date with household chores like cleaning and laundry. You won’t be able to do these in the first few weeks after your operation. Involve your coach in making the necessary preparations.

What to bring to hospital
You will need your toiletries, nightclothes and some loose fitting, comfortable day clothes. You will get dressed in normal ‘day’ clothes when you are in hospital. T-shirts and shorts are practical when doing exercises. Bring flat supportive shoes that are adjustable as your feet may swell after your operation, trainers are ideal. Shoes without a back or with heels are not suitable for safety.

Bring your usual medicines and a small amount of money, but leave valuables, jewellery, etc. at home. You may want to bring a few books or magazines. You will have access to your own television and telephone on the ward for a charge.

Start your checklist to prepare for your hospital visit
Remember:

- Toiletries - including hand wipes and moisturisers
- T-Shirts and shorts or comfortable day clothes
- Small change
- Nightclothes
- Flat supportive shoes
- Books, puzzles, magazines
- Pack all medication in original containers
- Ensure you have enough medication and will not run out
- Remove loose rugs
- Move furniture or other hazards
- Move items regularly used to be easily accessible
- Pack suitable clothing and toiletries
- Arrange care for pets and family
- Arrange discharge plans i.e. lift home
- Prepare food and meals for your convenience once home
- Freeze milk and bread for the first few days once home

Medication
You must bring all your medication to hospital in sufficient supplies to last for your entire hospital stay. We expect this to be four days including your day of surgery but please bring an extra few days’ supply. Bring them in their original boxes and not in dosette boxes. You should make sure before you come into hospital that you have enough supplies for when you return home, remembering that you may have limited
mobility to visit your GP or pharmacy. We will supply any painkillers or antibiotics that you may need in relation to your surgery. These drugs may all increase the risk of unpleasant constipation which can be avoided through a healthy diet as discussed earlier. You should inform your team if you feel you are getting constipated and they can prescribe appropriate medication.

The day of surgery

The majority of patients are admitted to hospital on the morning of their surgery. However it may be necessary to admit you on the day prior to surgery. The anaesthetist will make this decision and inform you.

Arriving in hospital

You will be given instructions on where to present yourself on the morning of surgery. You will be allocated a bed and a nurse will do some final paperwork. Once this is completed, you may have a long wait depending upon where you are on the theatre list and it would be advisable to bring something to read with you. A member of the orthopaedic and anaesthetic team will also see you, your operation site will be marked with a marker pen and a ‘TED’ stocking (anti embolic stockings) placed on your un-operated leg.

Nothing to eat or drink – fasting (‘nil by mouth’)

At the pre-assessment appointment the nursing team should give you clear instructions about fasting prior to coming into hospital for your operation. It is important to follow these. If there is food or liquid in your stomach during your anaesthetic, it could come up into the back of your throat and damage your lungs. If you are not having a general anaesthetic, you will still be asked to follow these instructions. This is because a general anaesthetic may be needed unexpectedly, and you need to be prepared.

Having a ‘premed’ (pre-medication)

This is the name for drugs which are given before some anaesthetics. Some premeds prepare you for the anaesthetic (for example a drug to prevent sickness), others help you to relax. They may also make you drowsier after the operation. If you think a premed would help you, please ask your anaesthetist.

Your usual medicines

It is important that you continue to take your usual medicines, including inhalers, unless your surgeon or anaesthetist has advised you not to.
**Glasses, jewellery, dentures**
You can wear your glasses, hearing aids and dentures until you are in the anaesthetic room. If you are having a local or regional anaesthetic, you may keep them on. Jewellery and decorative piercings should be removed. If you cannot remove your jewellery, it must be covered with tape to prevent damage to it or to your skin.

**The operation**

**Getting ready for theatre**
- You will be given a hospital gown to put on
- Jewellery should be removed or covered with tape to prevent damage to it or to your skin
- You can wear your hearing aid, glasses and dentures until you are in the anaesthetic room. If you are not having a general anaesthetic, you can usually keep them on during the operation.
- You may be asked to take off your pants for the operation, but you will be given a gown to wear to retain your dignity.
- The anaesthetic nurse will check your details again before taking you into the anaesthetic room.

**In the anaesthetic room**
This is the room next to the operating theatre. Several people will be there, including your anaesthetist and an anaesthetic assistant.
The anaesthetist will use equipment to measure:
- Your heart rate – three sticky patches on your chest (electrocardiogram or ECG)
- Your blood pressure – a cuff on your arm
- The oxygen level in your blood – a clip on your finger (pulse oximeter).

A needle is used to put a thin soft plastic tube (a cannula) into a vein in the back of your hand or arm. Drugs and fluids can be given through this cannula. **If needles worry you**, please tell your anaesthetist. A needle cannot usually be avoided, but there are things he or she can do to help.
Regional anaesthetics (spinal and/ epidural)

- Your anaesthetist will ask you to keep quite still while the injections are given.
- You may notice a warm tingling feeling as the anaesthetic begins to take effect.
- Your operation will only go ahead when you and your anaesthetist are sure that the area is numb.
- If you are not having sedation you will remain alert and aware of your surroundings. A screen shields the operating site, so you will not see the operation unless you want to.
- Your anaesthetist is always near to you and you can speak to him or her whenever you want to.

General Anaesthetics

There are two ways of starting a general anaesthetic.

- Anaesthetic drugs may be injected into a vein through the cannula (this is generally used for adults);
- You can breathe anaesthetic gases and oxygen through a mask, which you may hold if you prefer. Once you are unconscious, an anaesthetist stays with you at all times and continues to give you drugs to keep you anaesthetised.

As soon as the operation is finished, the drugs will be stopped or reversed so that you regain consciousness.

If you are having a general anaesthetic you are put to sleep in this room and the next thing you are aware is waking up in recovery. If you are having a spinal anaesthetic alone you are wheeled on a trolley or bed into the main operating room. The operating room is a bigger room with bright lights and there will be at least 6 people to help you across on to the operating table.

All anaesthetics may cause changes in:

- your heart rate
- your blood pressure
- your breathing.

Changes may also occur due to loss of blood, the use of surgical cement and the use of a tourniquet on your leg (knee replacements only). Your anaesthetist may intentionally adjust your blood pressure and breathing to control your response to surgery. The anaesthetist usually gives you light sedation along with the spinal anaesthetic. However you may at times be aware of people talking, noises of instruments like hammering and drilling.

General anaesthetic drugs are given continuously throughout surgery and are stopped when the operation ends. A spinal, epidural or nerve block injection will wear off some hours after the operation is finished.

An anaesthetist will stay with you for the whole operation and watch your condition very closely, adjusting the anaesthetic as required.
Blood transfusion
Occasionally you may lose a significant amount of blood during and after the operation.

- A blood transfusion can be used to replace the blood you have lost
- Usually this is blood from a volunteer who has given blood to help others (a blood donor)
- A blood transfusion will not be recommended unless you have a significantly low blood count
- Please ask your surgeon or anaesthetist if you would like to know more about blood transfusion and any alternatives there may be
- It may be possible to collect blood that is lost during the operation using a modern technique called cell salvage. The blood lost is collected in a sterile manner, processed and immediately returned back to you. It reduces the need to use bank blood.

After the operation

- You will have your own nurse in the recovery room. You will not be left alone
- There will be other patients in the same room
- You may need to breathe oxygen through a light plastic mask.
- You will have a drip (a bag of sterile water with added salt or sugar which is attached to your cannula and drips slowly into a vein)
- Your blood pressure, heart rate, oxygen level and temperature will be measured every 15 minutes. When you are waking up from a general anaesthetic you may experience joint stiffness, pain, nausea or vomiting.
- If you have a spinal or epidural anaesthesia, they will check the movement and sensation of both of your legs. Otherwise the pulse, movement and sensation of your operated foot will be checked routinely
- If you have pain or sickness, inform the nurse and they will treat it promptly
- Once you are pain free, the nurses along with the physiotherapists will help you to initiate the physiotherapy, namely, end of bed exercises
- When the recovery room staff are satisfied that you have recovered safely from your anaesthetic you will be taken back to the ward.
Pain relief after your operation

Pain relief
Good pain relief is important and some people need more pain relief medicines than others. On return to the ward the nurses will reassess the degree of pain you may have. **Be honest with your answers.** An assessment scale is used to measure your pain regularly. The nurses will ask you to rate your pain at rest and on movement. They may use a numeric scale of 0 – 3, 0 meaning no pain and 3 being severe pain or what is called a Visual Analogue Scale using pictures to compare your pain to. You may also choose the word that best describes your pain: No Pain, Mild, Moderate, Severe or Worst Pain Ever. Whichever tool is used it is important that you are honest about your pain so that you can receive the appropriate treatment for you. It is vital to the success of your joint replacement that you are not inhibited from exercising because of your pain.

What you may receive

**Tablets or liquids**
Tablets or liquids may be given to you to swallow. In our experience if you have had the surgical infiltration, your pain is well controlled in most cases with regular pain killer tablets reducing the necessity for stronger pain killer injections like morphine. If however, the tablets do not give you adequate pain relief then you may be started on a patient controlled analgesia (PCA) using a strong pain killer like morphine. They take at least half an hour to work and you need to be able to eat and drink and not feel sick for these drugs to work.

**Injections**
These are given into a vein for immediate effect, or into your leg or buttock muscle. Strong pain relieving drugs such as morphine and tramadol may be given by injection. You may need a single or a couple of these injections the same night and the following morning along with your pain killer tablets.

**Suppositories**
Certain painkillers are effective when given as a suppository, these are placed in your back passage (rectum). They are useful if you cannot swallow or might vomit.

**Patient Controlled Anaesthesia PCA**
Patient Controlled Anaesthesia PCA is a method of being in control of your own pain relief medication. It is administered by a special pump that contains a syringe of medication such as morphine. The pump is connected directly to your intravenous line. PCA allows you to administer your own pain relief as and when required.

**Nerve blocks**
If you have had a nerve block during your operation, it can give effective pain relief from 8-16 hours after the operation. When the sensation begins to return and numbness wears off, you must inform the nurse who will give you suitable painkillers.

**Epidural**
If you have an epidural left in after the procedure it is then connected to a pump through which you will get pain killer injections continuously. The nurses will do
frequent observations while you are on the pump. These are usually continued for not more than 24-48 hours but may be left in longer if deemed necessary. As the epidural can sometimes reduce your sensation to pass water you may need a urinary catheter to help you pass water. You will be started with oral painkillers before the epidural is disconnected.

**Occasionally, despite regular painkillers, you may experience stronger pain.** This may occur during physiotherapy exercises or walking. You will have additional painkillers prescribed to help relieve this pain but you have to ask your nurse for these. You must inform the nurses who will give you these extra painkillers. It is important that you are comfortable enough to be able to comply with physiotherapy to prevent any delay in discharge.

Good pain control helps you recover more quickly after your operation. It is important to make the doctors or nurses know if you are in pain, do not wait to be asked and do not feel afraid of being a nuisance. If your pain is effectively controlled, having post-operative complications are reduced. You sleep better, it helps your body heal more quickly and may help you leave hospital sooner.

You can get more information about pain relief from:
- The nurses on the ward
- Your anaesthetist
- The pain-relief team

**What will I feel like afterwards?**
How you feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

**After your operation**

**Back on the ward**
Following your operation and recovery, you will be taken in your bed to the ward where nursing staff will look after you for the rest of your time in hospital.
It is perfectly normal, in the initial stages of your recovery, to be connected to various pieces of equipment. These machines help the nurses monitor your blood pressure and pulse, as well as giving you fluids and possibly painkilling medicines through a tube into your vein. You may have oxygen via a mask or small tubes into your nostrils. Bandages over the wound on your hip will be looked at regularly and you may have a wound drain in your operated leg. This drain is normally removed within 24 hours of your surgery.

If you have had a spinal anaesthetic you may not be aware when you are passing urine – this is normal, the sensation will come back once the anaesthetic wears off (4 – 6 hours). It is common to have a urinary catheter inserted in theatre and the catheter will be removed the following day. There is a risk that you may feel nauseated following your surgery, especially if you have a general anaesthetic. It is important that you mention this to the nursing staff as soon as possible so that they can give you something to help reduce this. The nurses are there to reassure you, do not be afraid to ask them things you are not sure of.

Depending on the time of your operation, the staff will encourage you to start gentle exercises and may assist you to move from the bed to the armchair. Most patients will be able to walk on the same day of surgery. This early movement promotes good circulation and movement of your hip. Being in a more upright position will help reduce the risk of chest complications.

The day after your operation - Day 1
You will have a blood sample taken to assess your blood loss. A nurse will help you with washing and dressing and you will sit out of bed for your breakfast. You will have an x-ray but you can still mobilise and do your exercises prior to this being done. You may not feel like eating much on this first day, but it is important that you drink, little and often. You can sit in a chair and can walk to the toilet.

The physiotherapist will visit and assess you if they didn’t see you on the day of your operation. You will be given some gentle exercises to do. If you have any drains they may be removed.
**Exercises after surgery**
A Physiotherapist will show you how to walk, at first with a walking frame and will also help you with your exercises for your circulation and restoring movement.

**Exercises you should do**
1. Take several deep breaths every hour
2. When lying, bend and straighten your ankles making sure you move them fully. Keep your knee straight during the exercise so that you will also stretch your calf muscles. *Repeat 10 times, at least 3 times a day*

3. With your legs straight, pull your toes towards you and push your knees down firmly against the bed to tense the thigh muscles. Hold for five seconds and then relax. *Repeat 10 times at least 3 times a day*

4. Squeeze your buttock firmly together, hold for 5 seconds and relax. *Repeat 10 times, at least 3 times a day*

5. Lying on your back, bend and straighten your leg only as far as instructed. *Repeat 10 times, at least 3 times a day*
6. Lying on your back, slide your leg out sideways and bring it back keeping your trunk straight throughout the exercise. Keep your toes pointing towards the ceiling and do not twist your hip. 
*Repeat 10 times, at least 3 times a day*

If this is too difficult, wait until you see your physiotherapist.

*Once you are sitting in the chair you can still exercise your ankles and squeeze your buttock muscles together (exercise 2 and 4).*

7. When sitting in the chair, pull your toes up, tighten your thigh muscles and straighten your knee. Hold for about 5 seconds and slowly relax your leg. 
*Repeat 10 times, at least 3 times a day*

The walking sequence should be:

- Move your walking aid
- Step forwards with your operated leg
- Step forwards with your un-operated leg

From day 2 onwards (continued up to 6 weeks after surgery)

You will continue to progress your walking using a walking frame or elbow crutches, depending on your progress. You should also continue your circulatory exercises as outlined in day one.
Each day, with encouragement from the nurses and physiotherapists, you will become more independent. The physiotherapist will show you how to negotiate stairs safely. You will also be shown how to do other exercises to help strengthen your hip. These may be adjusted depending on your physiotherapist’s assessment of your progress.

1. Holding onto a chair take your leg out sideways and then slowly return it. You can progress the exercise by holding your leg outwards for five seconds. Make sure you keep yourself fully upright. 
   
   Repeat 10 times at least 3 times a day.

2. Stand holding onto a chair, lift your leg out backwards keeping it straight. Make sure you keep your back straight and don’t lean forwards. This can be progressed by holding your leg out backwards for five seconds.
   
   Repeat 10 times at least 3 times a day.

3. Stand holding onto a chair, bend your operated leg up in front of you (no higher than 90degrees).
   
   Repeat 10 times at least 3 times a day.

4. Stand holding onto a chair bend your heel up towards your bottom.
   
   Repeat 10 times 3 times a day.

5. Stand holding onto a chair, slowly bend your knees straighten up again.
   
   Repeat 10 times. 3 times a day
6. Stand, holding on to a chair, slowly push up onto your toes then lower back down. Repeat 10 times. 3 times a day

Stairs
Going UP stairs

- First take a step up with your un-operated leg.
- Then take a step up with your operated leg.
- Then bring your crutch or stick up onto the step.
- Always go one step at a time.
- If there is a rail hold onto this with one hand and you will be shown how to hold your other crutch or stick.

Going DOWN stairs

- First put your crutch or stick one step down.
- Then take a step with your operated leg followed by your un-operated leg.
- Always go one step at a time.
- Do not discard your walking aid until instructed.

You will be reviewed by the occupational therapist to make sure you can manage with your daily activities at home.

Discharge
Depending on the surgery undertaken, most patients will be able to go home two or three days following your operation. This will happen only if you and the team looking after you think it is safe. Before you go home you will be given advice on any new tablets, such as painkillers and when to start any tablets that were stopped. If you are able to attend your GP practice, your practice nurse can remove any clips and check your wound. You will need to make an appointment. If you cannot do this, we can arrange for a district nurse to come to your home, this will be confirmed by a letter. You will be given a spare pair of TED stockings to take home with you.
Any equipment you will need at home will have been discussed with the occupational therapist at the Joint Replacement School and delivered to your home before your operation. You should continue to do your exercises at home. The usual advice is twice a day. In general, it is better to do them little and often rather than in one long session.

Follow up
You will be seen at home by HART or CCT unless you live outside Harrow or Brent, in which case you will be referred to your local service for physiotherapy. You will also be seen by your consultant at around six weeks. If they have any concerns about your progress they will organise another consultation with your consultant.

Exercises and precautions once you are at home

Precautions
If after discharge your hip becomes excessively swollen, red, weeping fluid or unduly painful, please contact the ward sister, on one of the numbers listed at the end of this booklet.

Sleeping
We advise you to sleep on your back for the first six weeks. If this is not possible, we advise you to sleep lying on your operated leg. Remember that if you sleep on the side of your un-operated leg, then your operated leg is likely to cross over in the night, which increases the risk of dislocation.

Getting in and out of bed
Have a high bed if possible. If your bed at home is low, this will have been identified by the occupational therapist before your admission to hospital and will be raised if necessary. To get into a sitting position and get out of bed, push yourself up into a sitting position taking your weight through your arms. Keep your operated leg straight out in front of you and turn to sit on the edge of the bed as shown in the diagram. It is important that you keep the operated leg out to the side when getting out of bed.
To get into a sitting position and get out of bed:

1. Push yourself up into a sitting position taking your weight through your arms. Make sure you don’t bend any further forwards than 90 degrees.

2. Keep your operated leg straight out in front of you and turn to sit on the edge of the bed.

Sitting on a chair or toilet
You MUST NOT sit on a low chair or toilet seat or cross your legs, as you will be at risk of dislocating your new hip. If necessary the OT will have provided equipment to raise your chair, bed and toilet seat before you come into hospital for your operation.

When sitting down:
  1. Make sure you can feel the chair or toilet behind both legs
  2. Reach your hands back for the arms of the chair
  3. As you lower your bottom to the chair or seat, slide your operated leg out in front of you.
4. Toilet paper should be situated beside or in front of the toilet and not behind, to prevent you from twisting or bending too far.

5. When standing up from a chair or toilet keep your operated leg out in front of you. Bring your bottom to the edge of the chair or seat. Take your weight through your un-operated leg and push up from the chair or seat with your hands.

Kitchen activities
You may work in your kitchen when you get home but you may have to make some adaptations to care for your new hip.

- Do not bend to get to the bottom of your cupboards, fridge, freezer or oven
- Put the items that you use every day on higher shelves but not so high that you have to stretch for things beyond your reach
- Be careful carrying things around the kitchen when walking with sticks. Slide items along the work surfaces or use a trolley (this may be supplied)
- Be careful picking things up from ground or floor level such as the milk delivery. Try to arrange for the milkman to leave your milk where you can reach it without having to bend down
- You can use your ‘helping hand’ which will be given to you by the occupational therapist (if required), to pick up light objects from low levels, or ask someone to help you do this.

Bathing and showering
You will be assessed by the intermediate care team if you are able to get in and out of your bath or have a shower. Please strip wash in front of your basin until you have been assessed.

Use a shower where available - a walk in shower with a suitable seat is easiest. You should always use a non-slip mat and bath board in the bath or shower. If you have to climb into a bath, follow the instructions below:

- Place the showerhead in the bath and run the water to the preferred temperature
• Sit on the edge of the bath board and bring your legs into the bath keeping your operated leg as straight as possible and without twisting or rotating your leg
• When in the shower use the hose to pick up the showerhead and avoid bending forward. Always shower while sitting on the board
• Use a long handled bath brush, loofah or towel to wash your lower legs and feet. Do not bend down to your feet
• Reverse the procedure to get out of the bath, remembering not to bend too far forward
• You must always use the bath board for 12 weeks after your operation

If you find getting in and out of the bath difficult, try strip washing initially and return to the bath at a later date.

Household activities
• Do not bend to use low electrical sockets – leave appliances plugged in where you can
• Be careful hanging washing out to dry. Do not put the washing basket on the ground or floor. Put it on a garden chair or table near to the washing line
• Be careful when picking up the post or newspapers, feeding household pets, picking up your shoes or items from the floor. Use your ‘helping hand’.

In general, think HIP before TASK and spread household chores over the week. Please ask any of the therapists about anything you are concerned about.

Dressing your lower half
You should get dressed sitting on a suitable chair or on the edge of your bed. Take most garments over your head, where possible. You must not bend forward beyond a 90 degree angle to reach the foot on your operated side, nor should you lift your foot too far up towards you. The occupational therapist will show you at the joint replacement school how to dress your lower half without putting your hip at risk of dislocation and you may need a long handle shoehorn and ‘helping hand’.

Anti-embolic (TED) stockings
You must wear these stockings 24 hours a day for six weeks. You may remove them to bathe, and to have them washed, but it is important not to leave them off for any longer than 30 minutes in 24 hours.

Please make sure they are wrinkle free whilst on as wrinkles may cause problems. You may wash your stockings either by hand or washing machine at 40ºC and allow them to dry naturally.
Driving
Driving is permissible when you can sit comfortably in the car and when your muscle control provides adequate reaction time for braking and acceleration. Most individuals resume driving about six weeks after surgery. Please always check with your insurance company before starting to drive, otherwise you may not be adequately covered in the event of an accident. Please remember your hip precautions when getting in and out of the car. Ask your consultant or doctor at your six week follow up appointment if it is permissible for you to drive.

Bending down
Avoid bending down if possible. Use your ‘helping hand’. Hold on to a solid object for support. Slide your operated leg out behind you keeping the knee straight.

Getting in to a car
Particular care needs to be taken especially if the car seat is low. Have the seat as far back as possible and angled so that it is partially reclined. If possible, get in to the car directly from the drive or road rather than the curb or pavement. You may need a cushion to make the seat higher. Ensure the car door is held steady and approach the doorway and seat bottom first.

1. Place your right hand on the side of the windscreen and your left hand on the seat back.
2. Gently lower yourself down keeping your operated leg straight and out in front of you.
3. Slide back over the seat until your bottom reaches the handbrake.
4. Then lift both legs in together as your body turns to sit upright in the seat (you may need someone to help).

Sport
After 12 weeks you can return to certain sports. Walking and swimming are excellent but sports that require jogging and jumping are not, e.g. football, squash, tennis, athletics.
You may find that using a carrier bag on the seat helps you to turn smoothly. Make sure that you remove the carrier bag prior to the car moving. Keep your operated leg out straight in front of you whilst you are in the car.

**Getting out of a car**
Reverse the above. Only make short journeys of up to 30 minutes for the first 6 weeks and avoid using black cabs, as there is a high step up.

**Sexual Intercourse**
In the absence of pain, or advice to the contrary from your consultant, sexual activity may resume approximately six to twelve weeks after your operation. You should be the passive partner while you are recovering. There is a leaflet available on this subject. Please do not be embarrassed to ask any member of staff for a copy of the leaflet.

**Basic precautions**
It is important that for the first twelve weeks following your operation you take special care to protect the joint and prevent dislocation.

- **DO NOT** bend your operated hip more than 90 degrees (figure 1)
  - E.g. Do not sit in a low chair or bend down for an object on the floor
- **DO NOT** cross your legs in bed or when sitting (figure 2)
  - E.g. place a pillow between your legs when in bed
- **DO NOT** swivel or twist on your operated leg (figure 3)
  - E.g. take small steps when turning around

**Reminders**
- Loss of appetite is common for several weeks after surgery. A balanced diet is important to promote proper tissue healing and restore muscle strength.
- When walking do not twist your hip as you turn around, but take small steps instead
- Do not stand for prolonged periods as this may cause your leg to swell. When you are sitting or lying down, keep your leg raised by resting your foot and
ankle on a low stool, low chair or pillow until the swelling subsides. It is important to continue your foot and ankle exercises whilst you are resting.

- Contact your GP at once if you develop an infection anywhere in or on your body as it is essential to have it treated. Inform staff that you have had a joint replacement before any invasive treatment, e.g. Dentist.

The following are especially important for the first 3 months after your operation although it is advisable NEVER to sit on low chairs.

**DON'T's**

- Do not cross your legs
- Do not bend more than 90 degrees (a right angle) at your hip
- Do not bring your knee up towards your chest
- Do not bend towards your feet e.g. to tie your shoe laces
- Do not shuffle or swivel on your feet when turning
- Do not sit on low chairs, beds or toilet seats
- Do not kneel down
- Do not wear back-less shoes or slippers, e.g. mules or flip flops
- Do not force any movements of your hip and never turn your leg inwards with your knee and hip bent

**DO's**

- Do take small steps when turning round
- Do continue the exercises shown by the physiotherapist for at least 3 months
- Do use your walking aid for as long as recommended
- Do go for regular walks when you go home and try to increase the distance a little each day
- Do watch your weight. Being overweight puts an unnecessary strain on your new hip
- Do contact you GP at once if you develop an infection anywhere in or on your body as it is essential to have it treated
- Do inform staff that you have had a joint replacement before any invasive treatment, e.g. Dentist

**Exercises at four to six weeks after surgery**

Continue the other exercises you have already been taught. People who are more active may want to try the following exercises at around 4 - 6wks:

1. Lying on your un-operated side, keeping the lower leg bent for balance, lift the operated leg straight up.
   
   Repeat 10 times at least 3 times a day.
2. Lying face down, with your knee slightly bent, lift your foot towards the ceiling lifting your thigh off the bed. This exercise can be made easier by further flexing your lifted knee. Alternate this exercise to work both legs. 
*Repeat 10 times at least 3 times a day.*

![Exercise Image]

At six weeks after surgery
Your consultant or his team will review you in the outpatient department at the hospital.

Falls prevention advice
1. Consider removing loose rugs and matting. Alternatively, they can be secured to the floor by slip-resistant grips.
2. Ensure there are no trailing cables within your home e.g. from electrical appliances or the telephone.
3. Ensure you have a night light next to your bed so you can make your way to the toilet safely at night.
4. Ensure there is sufficient room to manoeuvre around the room with your walking aids. If necessary, consider removing excess furniture or ornaments.
5. Cordless telephones are useful, as they can be taken from room to room. They avoid you rushing to get to the telephone and provide you with an accessible means of contacting someone in an emergency.
6. Auto-dial alarms, which can be worn as a bracelet around your wrist or on a pendant, can be useful. This will enable you to call for assistance if you have a fall.
Useful Contact Numbers

Hospital…………… Northwick Park Hospital 020 8864 3232
Central Middlesex Hospital 020 8965 5733

Admissions Office……. 020 8869 2055

Orthopaedic Ward……. Abbey suite at Central Middlesex Hospital 020 8453 2003
Evelyn ward at Northwick Park Hospital 020 8869 2466 / 2467 / 2468

PALS is a confidential service for people who would like information, help or advice about the services provided by any of our hospitals. Please call 0800 783 4372 between 10am and 4pm or e-mail pals@nwlh.nhs.uk.

NHS Free Smoking Helpline: 0800 022 4 332

Useful organisations

Age Concern
63a High St, Uxbridge, UB8 1JP
01895 231841
01895 238593

The Arthritis Research Campaign
PO Box 177, Chesterfield, Derbyshire, S41 7QT
Tel: 0870 850 5000
www.arc.org.uk
Funds research and produces a free range of leaflets and information booklets.

Arthritis Care
18 Stephenson Way, London, NW1 2HD
Tel: 0207 380 6500
www.arthritiscare.org.uk
Offers self-help support and a range of leaflets on arthritis.

Patients Association
PO Box 935, Harrow, Middlesex, HA1 3YJ
Tel Helpline: 0845 608 4455
www.patients-association.com
Provides a helpline, information and advisory service. It also campaigns for a better health care service for patients.
Internet Sites
• Royal College of Anaesthetists
  www.youranaesthetic.info
• European Society of Anaesthesia and Pain Management
  www.postoppain.org
• Arthritis Research Campaign
  www.arc.org.uk
• Best Treatments
  www.besttreatments.co.uk.
• National Institute for Clinical Excellence
  www.nice.org.uk
• NHS Direct Health
  www.nhsdirect.nhs.uk
This Trust has developed a policy in accordance with the Data Protection Act 1998 and the Human Rights Act 1998. All of our staff respect these policies and confidentiality is adhered to at all times. www.dataprotection.gov.uk

All patient leaflets are regularly reviewed and any suggestions you may have as to how they may be improved would be valuable.

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Reference number: 202010
Issue date September 2010
Review date September 2012