Whittington Health
NHS Trust

Patient Information and Consent For Total Hip Replacement Surgery

A patient's guide

Key messages for patients

- **Please read this information carefully,** you and your health professional will both sign a consent form to confirm your wish to proceed with surgery.
- **It is important that you bring the attached consent form with you when you are admitted for surgery.** You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or with your surgeon when you come in for your operation.
- **Please bring any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies)** and any information that you have been given relevant to your care in hospital, such as x-rays or test results.
- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of the pre assessment or medical team. If you have diabetes, specific individual advice will be given on your medication at your pre-operative assessment appointment.

  If you have any other questions or concerns about this procedure after reading this guide, please call the **Orthopaedic therapy team** on 0207 2885613 or **Enhanced Recovery Nurse** via the main hospital switchboard on 020 7272 3070 (Bleep 2746).
- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

Important things you need to know

Patient choice is an important part of your care. The information in this leaflet is a general guideline. Your doctor may give you extra or slightly different advice to suit your particular needs.

You have the right to change your mind at any time, even after you have given consent and the procedure has started if it is safe and practical to do so. If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist,

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form.

Information and support

This information is intended to help you understand your operation, and to help you to prepare yourself for it. Some patients will want to know even more details than provided here. Please ask us, and we will be happy to add additional notes or comments for your assistance. Please do not proceed with this surgery unless you are satisfied you understand all that you want to about the operation.

An explanation with this level of detail can cause some patients to worry, be concerned about the operation, or be uncertain about whether to go ahead. If this is the case, please let your doctor or nurse know, so we can address any matters of concern.

About Total Hip Replacement

The operation replaces a worn out hip joint, which has usually been damaged by arthritis, or occasionally by another cause. The hip joint is a ball and socket joint, formed by a socket in the pelvis (the acetabulum) and a ball on the head of the thighbone (femur). Over many years the smooth covering (cartilage) of the joint may be worn away, exposing the underlying bone and forming an “arthritic” joint. As a result, the joint becomes painful, movement is restricted and function impaired.

What types of hip replacement are there?

There are many different types of total hip replacement in common use and the principles are all similar. There are two main components: one to replace the worn socket called a “cup/socket” and another to replace the worn ball of the femur called a “stem”. The cup tends to be made from high-density polyethylene (a form of plastic), ceramic or metal and the stem is made of metal.

These implants are fixed in place using special acrylic cement (“cemented” type) or coatings that allow them to bond directly to the bone (“uncemented” type). In uncemented types, occasionally one or more screws are passed though the cup into the bone of the pelvis to provide initial support of the component whilst the bone grows onto it.

Once in place, a ball is attached to the stem to allow it to smoothly articulate with the cup, forming your new ball and socket joint. Usually a metal ball is used, but sometimes a ceramic one may be used instead.

Note: metal-on-metal hip replacements are not used in this hospital.

Intended benefits

The aim of surgery is to improve your quality of life, primarily by relieving your pain. If your hip is stiff, the range of movement may also improve, but this is not always the case. Replacement hip surgery is considered by some to be one of the greatest surgical revolutions in the past few decades. However, no major surgery should be entered into lightly, so in general terms before you proceed with surgery, your pain should be intrusive and often troubling you at night, your walking distance restricted, and pain-killers will have often failed to control your pain. You may already be using a walking stick. You will probably be struggling to manage your everyday activities, work and recreation. You may have already tried a course of physiotherapy.

Who will perform my procedure?

This procedure will be performed either by a consultant or a designated surgeon either competent to perform the surgery alone or under the supervision of a consultant surgeon.

Alternative procedures that are available

Unfortunately, there is no alternative to hip replacement. If you wish to avoid having a hip replacement all together, there are other options available to help alleviate your pain and improve your mobility including:

- Physiotherapy and gentle exercises
- Weight loss
- Stopping strenuous exercises or work
- Medicines, such as anti-inflammatory drugs (e.g. ibuprofen or steroids)
- Using a stick or a crutch or mobility scooter
- Hip fusion (arthrodesis)

Some of the procedures above will not be appropriate for you and your hip, especially if you want to regain as much physical activity as possible. You should discuss all possibilities with your surgeon.

Significant, unavoidable or frequently occurring risks of this procedure

A hip replacement is a major surgical operation and is usually very successful. Over 90% of people come into hospital, have the operation, go home again and recover with no unexpected problems. Surgery should not be undertaken lightly and it is inevitable that with major surgery that there are some risks. A small proportion of patients do have lasting symptoms, which are difficult to account for or explain/rectify.

Detailed below are risks you should be aware of, but of course try not to worry about them too much. Remember again that over 90% of people are very pleased with their hip replacement, their pain is relieved, and their quality of life is dramatically improved.

Common Risks (2-5%):

- **Blood Clots:** Blood can clot in the legs following surgery, causing a ‘deep vein thrombosis’ (DVT). To try and prevent this, various measures are taken whilst you are in hospital and you are given special elasticated stockings to wear. Occasionally a blood clot can break off and go to your lungs (a pulmonary embolism – ‘PE’), causing severe breathing problems, or even death. To reduce the risk of a blood clot developing whilst in hospital, most patients are given a daily injection of a drug to thin the blood. Upon going home, a different and more convenient drug, in the form of a tablet, is usually provided instead of injections. This will need to be continued for a total of 28 days since surgery. You can also help reduce the risk by keeping well hydrated after surgery and keeping mobile.
- **Bleeding**: this is usually small and can be stopped in the operation. However, large amounts of bleeding may need a blood transfusion or iron tablets. Rarely, the bleeding may form a blood clot or large bruise within the wound which may become painful & require an operation to remove it.
- **Pain**: the hip will be sore after the operation. If you are in pain, it’s important to tell staff so that medicines can be given. Pain will improve with time. Rarely, pain will be a long-term problem. This may be due to altered leg length or any of the other complications listed below, or sometimes, for no obvious reason.

- **Dislocation:** This is most common in the early period following surgery and may be caused by crossing your legs, twisting badly on your leg, or sitting in a low chair. Usually a brief anaesthetic is required to get the hip back into joint. On rare occasions the hip may need to be revised (further surgery) to control this problem.
- **Leg Length Discrepancy:** We always try to give you equal leg length following surgery, but some variation is common and sometimes the leg is lengthened or shortened. Usually this is not noticeable, but on rare occasions, the heel and sole of one or other of your shoes may need to be raised or further operation can be performed to correct this.
- **Loosening, wear and long term failure:** It is inevitable that all hip replacements wear with the passage of time. Failure of a hip replacement is usually caused by loosening. It is very rare that components themselves break. Loosening is a progressive problem, over many years. As a rough guide, 10% of hip replacements will fail by 10 years, but around 80-85% of hip replacements are still in place and functioning well 15 years after surgery. On rare occasions there can be problems in the early period after surgery, necessitating further surgery.
- **Swelling:** It is common for your leg and ankle to be a little swollen for some time after surgery. This gradually improves over a period of months. If you are concerned about this after discharge from hospital, you should see your GP or specialist again. It may help to elevate the foot of your bed by 10-15cms, or put some old duvets/blankets under the mattress, for a few weeks after surgery.
- **Other medical problems:** Major surgery can sometimes be followed by other unexpected medical problems. These could include poor kidney function with reduced urine output, the gut temporarily failing to function, constipation, poor bladder function, a chest infection, etc. To try and prevent constipation, which can be exacerbated by the pain killers required after surgery, laxatives are often prescribed.

Uncommon: (1-2%)

- **Infection:** With careful surgical techniques, sterility and antibiotics, infection is a rare complication. It is, however, a very serious complication and the wound site may become red, hot and painful. There may also be a discharge of fluid or pus. This is usually treated with antibiotics, but an operation to washout the joint may be necessary. In rare cases, the implants may be removed and replaced at a later date. The infection can sometimes lead to sepsis (blood infection) and strong antibiotics are required.
- **Trochanteric Bursitis:** Some patients develop discomfort/pain/tenderness after surgery, over the hip wound and bony prominence of the hip, described as '*Trochanteric Bursitis*', which can cause irritation for some time in a minority of patients. Generally this settles with time, facilitated by physiotherapy and/or an injection to the tender area, but occasionally persists and rarely can be difficult to resolve.

Rare Complications: (<1%)

- **Nerve Damage:** There are major nerves around your hip and these can occasionally be stretched or damaged, leading to profound weakness and loss of feeling in your thigh, leg or foot, which can sometimes be painful. This may require further surgery and a splint for the foot.
- **Bone Damage:** the thigh bone may be broken when the implant (metal replacement) is put in. This may require fixation, either at time or at a later operation.
- **Wound Healing Problems**: the wound may become red, thickened and painful (keloid scar) especially in Afro-Caribbean people. Massaging the scar with cream when it has healed may help.

- **Major Blood Vessel Damage:** this is rare and may require further surgery by the vascular surgeons.
- **Pulmonary Embolism (PE):** this is a consequence of a deep vein thrombosis (DVT). It is a blood clot that blocks blood flowing properly through the lung. This can make breathing very difficult and it can be fatal. By using strategies to prevent DVT (described above), the risk of a PE occurring is extremely low. If you have a personal or family history of blood clotting problems, please ensure the pre-assessment nurse and medical team are made aware.
- **Death:** There is a very small mortality rate (risk of death) with such major surgery. Whilst extremely unlikely to happen, when an operation is recommended, this is always a consideration. Very rarely, someone can have a major heart attack, major stroke, or other medical problem, from which they do not recover.

Revision surgery

As already mentioned, a few hip replacements do run into problems. Some hip replacements wear out or loosen and become de-bonded from the bone at a later date, requiring a revision of the replacement. Further surgery is described as “Revision Surgery”.

Revision surgery is complicated and the nature of surgery required is different in every case. However, the general principles of surgery are exactly the same, although the duration of surgery and the post-operative recovery is more prolonged. Different or more specialised implants are required to reconstruct the hip, sometimes using bone graft. The general plan of post-operative mobilisation, care and precautions are often identical. Sometimes it is necessary to avoid weight bearing for the first few weeks and keep you walking with crutches for longer. Unfortunately, as a revision procedure is a more major operation, the potential complications are also greater.

Your Journey

Outpatient appointments

After you and your consultant have decided that a total hip replacement is the most appropriate treatment for you, preparations for a total hip replacement begins several weeks ahead of your surgery date.

Pre-admission appointment

All patients scheduled for surgery are seen by the nursing team in a pre-admission appointment in **clinic 1A**, on level 1 just before the orthopaedic clinic. We will ask questions about any medical conditions you have and whether you are on any medication. Please **bring all your medications** and any packaging (if available) with you. It is very important that long term conditions (e.g. high blood pressure, diabetes, and heart or lung disease) are well managed before we perform your operation. We will check your blood pressure, perform blood tests and record a heart tracing (ECG). In some cases, further tests or investigations may be necessary to help us plan the best possible anaesthetic care for your operation. This session can take up to an hour.

You will be given a form to fill in about your house. **Please complete this form and bring it to joint school.** The occupational therapist will use this to help you prepare for coming home following your operation. They will determine if you will require equipment and organise any equipment to be in place prior to your admission to hospital.

Please make sure you tell your GP you will be in hospital, as they may be able to help you prepare for coming home again and may wish to visit you after discharge.

Pre-existing medication

Generally, you should continue all your medication until admission to hospital. However, there are some circumstances where this may not be the case, and some of these are detailed below:

I. **Aspirin:** Some patients take Aspirin for chest pain or to prevent a small stroke or TIA - typically a low dose of 75mg (half a junior Aspirin). Please let the pre-assessment nurse know well in advance as this may need to be stopped/reduced around 10 days before surgery.

II. **Clopidogrel (Plavix), Warfarin and other blood thinning drugs:** Some patients may be taking Plavix, typically for a heart problem, and this generally needs to be stopped 7-10 days before surgery. Certain anti-blood clotting drugs, such as Warfarin or Heparin may also need to be stopped, so again, please discuss this at your pre-operative assessment prior to surgery.

III. **Methotrexate and other Rheumatoid Arthritis drugs:** Some patients with rheumatoid arthritis take a drug called methotrexate and this may need to be stopped a week or so before surgery. Other patients take a Cytokine Inhibitor or anti-TNF drug, which may need to be stopped. Generally this will be considered in consultation with your rheumatologist.

IV. **Diabetic Drugs:** Some patients with Diabetes take a drug called metformin which may need to be stopped on the morning of surgery. Special arrangements will be necessary for patients on Insulin. When you attend your pre-operative assessment appointment prior to surgery, a nurse will discuss this with you.

V. **Non-Steroidal Anti-Inflammatory drugs (NSAIDS):** Drugs such as Neurofen (Ibuprofen), Voltarol (Diclofenac), Naprosyn (Naproxen), Celebrex, etc. (there are many more) are all similar non-steroidal anti-inflammatory drugs and are used very effectively for pain relief. However, these drugs also affect the way your blood clots during surgery. You will be advised when to stop them at your pre-operative assessment appointment.

VI. **Hormone Replacement Therapy (HRT) and the Oral Contraceptive Pill (OCP):** Many types of HRT and OCP contain oestrogen, which can be associated with an increased risk of a thrombosis (blood clot), which is also a risk after hip replacement surgery. It is generally advised to stop HRT or the OCP four to six weeks prior to surgery and not to recommence these until four to six weeks later following discussion with your GP (unless the drug is a progesterone only medication). If you have stopped the OCP, then obviously alternative contraceptive precautions are necessary, until the OCP is established again.

Enhanced recovery programme

Whittington Health runs an Enhanced Recovery Programme for patients undergoing joint replacement surgery. We will do everything that we can to make certain that you get the best result possible by supporting you to look after your own care**. Discharge is expected to be between one to three days.**

Joint School

This is a key part of the Enhanced Recovery Programme and is an important information giving session that you **must** attend before your operation. We encourage you to bring a partner with you (relatives, friends or carers). This person will then also understand your operation and be better able to support you.

The joint school is run by nurses and therapists and its aim is to educate you and your partner about the joint replacement you are about to undergo, including your post-operative care and discharge planning.

Topics that will be discussed are as follows

- Ward routine
- Day to day plan of care
- Anaesthetic and pain relief
- Anticoagulation medication
- Discharge planning and discharge criteria
- Exercises and progression of mobility

At joint school the therapy team will discuss how you are currently completing your activities of daily living, both personal and domestic. The therapists will advise and plan with you how you will manage these activities after surgery and may provide you with some adaptive equipment, for example, a frame to assist you on and off the toilet. At Joint School, you will also meet with a Pharmacist and Pain Nurse Specialist, who will discuss some of the strategies we will take to minimise your pain after surgery.

To optimise your outcome, please ensure you are as fit as possible prior to surgery. This includes regularly performing the exercises as shown later in this factsheet, not smoking and losing weight where possible.

What to bring to hospital

You will need your toiletries, nightclothes and some loose fitting comfortable day clothes as you will get dressed in normal day clothes whilst in hospital. Bring flat supportive shoes, trainers are ideal, **shoes without a back are not suitable**. Please bring your usual medications, small amount of money, but leave valuables jewellery etc. at home. You may want to bring a few books or magazines.

Check list to prepare for your hospital visit

Equipment has been delivered: if not contact therapy office	□
Toiletries	□
Loose fitting comfortable day clothes	□
Nightclothes	□
Flat supportive shoes/slippers	□
Small change, Phone, charger, Books, magazines etc	□
Medication in original boxes	□
Ensure home set up is easy to get around with crutches	□
Move regularly used items to be easily accessible at home	□
Prepare food and meals for your convenience once home	□
Arrange lift home	□

On the day of the operation

Food and drink

For a safe anaesthetic, it is essential to follow instructions you have been given about eating and drinking before your operation.

- ✓ Continue to eat solid food and milky drinks until *six hours before* surgery.
- ✓ Continue to drink regular clear fluids (a clear fluid is fluid you can *see through*, e.g. water, very weak squash, black tea or black coffee – i.e. no milk) until two hours before surgery.

For **morning surgery**, this means:

- You can eat until **2am** the night before, and we would encourage you to have a late-night snack.
- Do not eat sweets or chew gum after this time.
- To avoid dehydration, please **continue** to drink until 6am on the day of your surgery.

For **afternoon surgery**, this means:

- You can eat until **7am** on the morning of your surgery, and we would encourage you to have an early breakfast.
- Do not eat sweets or chew gum after this time.
- To avoid dehydration, please **continue** to drink until 11 am on the day of your surgery.

Very occasionally the order of the list may change on the day of your surgery. If this happens you will be advised what time you may continue drinking clear fluids up until after you have seen the doctor.

If you smoke, please do not have a cigarette for at least eight hours before the operation as it reduces the amount of oxygen carried in the blood, amongst other harmful effects.

Admission to Hospital

We will admit you to a ward or the Patient Admission Unit at 7am or the time according to your admission letter, on the day of your surgery where:

- Nursing staff will check your address details, blood pressure, pulse, temperature and respiratory rate.
- You will be measured for surgical stockings, which will be applied to the leg that is not operated on.
- The medical team will confirm your consent to proceed with the operation and mark the leg that will be operated on.
- You will be seen by the anaesthetist who will discuss the anaesthetic that will be used.
- You will be asked to change into a hospital gown.

The nursing staff will take you down to theatre when the surgeon is ready to start your operation.

Blood transfusion

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it and you consent to us doing so. Any questions can be discussed at pre-admission.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read.

Hair removal before an operation

If this is necessary, your healthcare team will use an electric hair clipper with a single-use disposable head on the day of the surgery. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

Anaesthesia

This procedure involves the use of spinal or general and/or regional anaesthesia. Local anaesthetic nerve blocks may also be performed which reduce post-operative pain. We explain the different types of anaesthesia or sedation we may use below. You will see an anaesthetist before your procedure.

Before your operation

The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together. To inform this decision, they will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- Your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.
The anaesthetist may then give you pain relieving medication to ensure you have a certain level in your system before the operation. They may also give other medication, depending on your health and fitness.

Moving to the operating room or theatre

You will be asked to change into a theatre gown (and dressing gown to keep warm) before we take you to the operating theatre for your operation. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting**.
Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) will be inserted. If a regional anaesthetic (a spinal or an epidural) is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing and replacing fluids if needed.

Regional anaesthesia

Regional anaesthesia includes, spinal, or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time.
Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

Local anaesthesia

A local anaesthetic medicine may be injected into the skin and tissues around the surgical site to help with pain relief after the operation.

Sedation

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used in addition to a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during the procedure. You may remember a little about what happened but often you will remember nothing.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health. Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties. Local or regional anaesthesia can minimise some of these effects, but as it wears off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks 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) or surgery which is complicated, long or performed in an emergency.

Very common (1 in 10 people) and common side effects (1 in 100 people)

- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision, headache
- Bladder problems, including retention of urine which may require a catheter inserted
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

Uncommon side effects and complications (1 in 1000 people)

- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications

- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death – this is extremely rare, with an approximate risk in the UK of 1 in 200,000 people.

For more information about anaesthesia, please visit the Royal College of Anaesthetists' website: www.rcoa.ac.uk

After your surgery

Transfer to the ward

After your surgery you will be taken to the recovery room for a period of observation where you will be looked after by specially trained nurses. You can expect to stay here for between 30 minutes to one hour. You will then be transferred to the ward once the recovery team are happy that you are comfortable and that all your vital signs are satisfactory.

If you have had a spinal anaesthetic, it is quite normal for your legs to feel numb. Normal feeling will usually return within 12 hours On the ward, the nursing staff will continue to monitor your observations (blood pressure, heart rate and respiratory rate) until you are fully recovered from the anaesthetic. You will be allowed to start eating and drinking when you feel ready.

After certain major operations you may be transferred to the intensive care unit (ITU) or a high dependency unit (HDU). These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect. If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.

Most people will be admitted to **Thorogood Ward**. Visiting hours for this ward are between 2pm – 8pm. These visiting hours are in place to enable essential rehabilitation and rest to occur during the day (Thorogood Ward **0207 288 5445**).

Wound dressings

The wound is covered with a white absorbent and plastic dressing. This will be removed at 12 days post-surgery. Skin closure is Consultant specific and will be discussed during your hospital admission.

Physiotherapy

Your rehabilitation will start on the day of your operation. The physiotherapist will see you regularly and will show you some exercises to do help you walk using appropriate walking aids (such as a frame or crutches).

The rehabilitation programme is outlined later in this guide and you should familiarise yourself with the recommended exercises and precautions.

It is important to actively participate in these sessions. You will experience some pain, this is a direct result of the operation and this will be different to the pain you had before the operation. You will be given regular painkillers and should request extra painkillers if your pain is not controlled.

Eating and drinking

After this procedure, you should commence eating and drinking as soon as you feel able. The nursing staff will advise you on when this is appropriate.

Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

Leaving hospital

Generally most people who have had this operation will be able to leave hospital two or three days after surgery. Your physiotherapist will have instructed you on an exercise programme to continue when you leave us and will have arranged some outpatient physiotherapy sessions. The staff will have discussed with you appropriate seating, bathing and exercise levels.

You will be given some surgical elastic support stockings in hospital to help prevent blood clots forming in your legs during and after surgery. You should wear these for six weeks, if you can tolerate them during this period.

Once you are home, continue with the exercise regime you discussed with the physiotherapist. Always try to get out of bed on the same side as your operation for the first six to eight weeks. Also, lie flat on your bed for half an hour twice a day, which will help stretch your hip. Sleep with a pillow between your legs for the first six weeks. When you are sitting, be it on a chair or a bed, never let your knee be higher than your hip. If this does happen, your hip will bend (or flex) too far, and may pop out of joint (dislocate). Likewise, when you get up from a chair, shuffle yourself to the front of the chair and push up from the arms, without leaning forward too far. Again, if you lean forward too far this may flex (or bend) your hip too far and the hip may pop out of joint.

The physiotherapists can advise you at joint school about obtaining a toilet seat raise and other adaptations to keep your hip safe. Small aids such as a grabber (so you don't have to bend down) can be purchased on the ward.

Resuming normal activities including work

You may find that your hip is rather stiff and might be painful for several weeks.

You will need to use walking aids until you have developed enough strength and control to allow you to walk safely without a limp. Many patients are ready to return their crutches to us within two months following surgery. There is, however, no great urgency to stop using your crutches and it is important to be safe. Some people find a walking stick helpful in the longer term after a joint replacement (which you need to hold in the opposite hand).

It takes time to recover from the operation but as your range of movement and strength improves your comfort and functional ability should get better. We expect to see the most improvement in the first three months but many patients report progressive improvement up to 12 months or more after the operation.

Even in the long-term, there is a small risk your hip can dislocate (pop out of joint). Remember always try to avoid low chairs/sofa's. Try to sit down with your legs slightly apart. Do not cross your legs. Be careful sitting in a bath and preferably use a shower, especially for the first few months after surgery.

Your return to work

You should be able to return to sedentary (seated) work as soon as you feel comfortable to do so. For the first four to six weeks you should try and avoid any strenuous physical activity until the soft tissues have healed satisfactorily. During this period of time, you will be able to walk and exercise your hip, but it is not a good idea to cycle, or to take part in vigorous swimming.

Other points to remember once discharged

1. **Sitting:** As already mentioned, avoid sitting in low chairs. When you stand up from a chair, keep your operated leg in front of you and take the weight through your un-operated leg. You should shuffle forwards to the edge of the chair before attempting to stand and push up with your arms. Sitting down is the reverse process of standing, gently lowering yourself to the front of your chair, taking weight through your un-operated leg. Remember not to cross your legs when sitting.
2. **Sleeping:** Sleep on your back for the first six weeks following surgery, keeping the pillow between your legs at night during this period. Later on it is usually better to sleep on your operated leg.
3. **Getting out of bed:** Get out of bed on the same side as your operated hip for the first few weeks, if possible. Again, standing up from bed is similar to standing up after sitting in a chair. If your bed is very low, you may need to have a higher bed.
4. **Driving:** When you are driving, if possible use a two-door car and have the seat as far back as possible. Stand on the road not the pavement and gently lower yourself into the car, taking weight through your un-operated leg, keeping your operated leg straight in front of you. You can start driving again, usually six to eight weeks following surgery. You must be able to do an emergency stop and should inform your insurance company before you start driving again.
5. **Sexual intercourse:** You can soon enjoy normal sexual activity following surgery. Remember that you must not bend your hip further than a right angle, or 90^0, but it is usually safe to let your knees roll out. Initially it is best for you to be on your back, but as time goes by, you will be able to become more adventurous.
6. **Toilet seat raise:** You should continue to use this for 6-12 weeks after surgery.
7. **Socks and shoes:** If you have difficulty putting on shoes or stockings, use a long shoe horn, or a special gadget which is available from the Physiotherapist to help.
8. **Sports and hobbies:** Low-impact sporting activities are encouraged after a hip replacement operation. Your doctor will indicate when you can return to activities such as golf, walking, cycling and swimming. If you take part in moderation, they are beneficial for not only your hip function, but also your general health. It is not a good idea to return to physical activities that involve turning, twisting, jumping or running because this can lead to premature loosening or wear of the hip replacement. You can discuss this with your consultant.

9. Flying: Most Orthopaedic surgeons advise their patients not to fly for at least six weeks after a THR. Please discuss this with your surgeon at your outpatient appointment

10. Leg swelling: Swelling is a normal part of the healing process following a hip replacement. Your hip and leg including your ankles may remain swollen for several months after your surgery: To manage this, it is recommended that you rest for up to an hour in bed during the day. After you no longer have to adhere to your hip precautions it is fine to elevate your legs on a footstool. Ice also helps to relieve pain and swelling. You can apply ice or a bag of frozen peas, but do not leave the ice on for more than 20mins at a time. Make sure that it is wrapped in a thin clean towel.

11. Wound care: On discharge the nurse will give you information regarding removal of dressing and who to contact if concerned once home. **Please ring the Enhanced recovery nurse or ward if you are concerned regarding the following**

- Increased pain around wound
- Increased swelling
- Increased redness
- Increased soiling of dressing
- Temperature over 38 or excessive sweating or shivering

Follow up care

Enhanced recovery nurse

You will be given the contact details of the enhanced recovery nurse when you are discharged. They will phone you within 3-4 days after discharge to discuss progress. We advise you to call the nurse should you have any concerns after you have gone home. They will advise you or direct you to the right professional to address your concerns.

If you have any concerns out of hours please call Thorogood ward on 020 7288 5445.

Practise nurse

You will need to arrange an appointment with your Practise nurse at your GP for removal of dressing. The nursing staff will give you a letter on discharge with all the relevant details for the nurse.

Physiotherapist

The physiotherapists on the ward will give you an appointment to attend the physiotherapy department six weeks after your operation. If you have any questions or concerns before your appointment, please call the orthopaedic therapy office on 020 7288 5613.

Doctors

Pending on your Consultant, you will be given an appointment to attend a follow up clinic at two or six weeks after the operation to see your consultant and their team. The clinic is usually held in 1B at The Whittington Hospital.

Rehabilitation & Exercise

Exercise is important both before and after any operation. To gain benefit from exercise you should gradually increase your activity daily, aiming to exercise little and often.

We recommend that you do not sit still during the day for more than one hour. Get up and move around.

Your rehabilitation will start on the day of your operation. It is important to actively participate in physiotherapy sessions. **The more you put in the quicker and better your recovery is likely to be**. You will experience some pain, this is a direct result of the operation and will be different to the pain you had before the operation.

You will be given regular painkillers and should request extra painkillers if your pain is not controlled.

The rehabilitation progress is set out below. This is a guide and can vary between patients, depending on individual factors (e.g. other medical problems, weight-bearing status).

On the day of your operation (day 0)

- A few hours after you return to the ward, providing your pain is controlled and your observation are within normal limits, your rehabilitation will start.
- The physiotherapist will assist you to get out of bed and sit in the chair. If you are able to, you will also go for a short walk with a walking aid.
- The physiotherapist will show you some exercises and answer any questions you may have.
- You will be provided with pain killers, including long acting morphine tablets, for 48 hours. If you need additional morphine to control the pain please ask the nurses.

Day 1

- This morning the nursing staff will assist you to wash. You should be able to wash the upper half of your body.
- Any drains or drips you have had in are likely to have been removed. You will be shown how to get out of bed by the nurses or therapist.
- You should wear some comfortable loose day clothes during the day. Pyjamas and nightdresses should be worn at night time only.
- The physiotherapists will also assess and teach you the correct way of getting in and out of bed and in and out of chairs. They will also advise you on any aids that you might need to assist you do this safely.
- The physiotherapists will review your exercises and you will be expected to do them independently every couple of hours throughout the day.
- The therapist will continue to practice walking, with the aim for you to be independent on elbow crutches. You will be encouraged to sit in an armchair for as long as you can tolerate. Lying in bed for long periods should be avoided, as it can lead to complications. You will be encouraged to walk to the bathroom from today, with supervision if required.
- One of the Orthopaedic doctors will come and review you.
- A blood test will be performed and you will have an x-ray of your new hip within the first couple of days.

Day 2

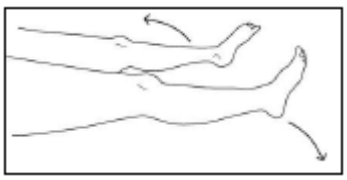
- You should try and be as independent as possible during the day; this includes getting dressed and taking yourself to the bathroom. The long acting morphine will be replaced with milder pain killers, however please let the nurses know if your pain is not controlled.
- The therapists will review your exercises and progress you onto crutches if you are able to. You should use your crutches (with supervision if required) little and often - this gives you more practice on them before you go home. Most patients are discharged on crutches.
- You should continue to do your exercises throughout the day. Exercising during your physiotherapy sessions is not enough.
- If you need to do stairs we will practice these with you. Most people manage stairs relatively easy.
- Some patients are able to go home today.

Day 3

- Most people will go home by the third day following surgery. The physiotherapist will practice steps and stairs with you and your walking practice will continue.
- You will now be getting in and out of bed and walking independently with an aid. If your wound is healing well, you will be discharged on this day.
- Your discharge will be planned with you and your family. The nursing staff will ensure that you have the following in place before going home:
    - Correct tablets including pain killers and anticoagulant
    - A letter will be given for the Practice nurse to review your wound
    - An appointment to see your consultant after surgery
    - An appointment to see the physiotherapist
    - A letter for your GP
    - Enhanced recovery nurse phone number for any queries after discharge.

Exercise programme

1. Lie on your bed. Move your leg sideways and then move it back to midline. Remember to keep your toes pointing up to the ceiling on this exercise. Repeat 5-10 times.

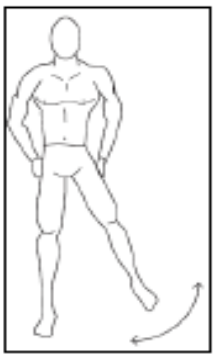


2. Lie on your back. Put the leg that you operated on out straight and other leg bent. On your straight leg - pull the toes up, straightening the knee and lift the leg to approximately 20cm off the bed. Hold for five seconds then relax slowly. Repeat 5-10 times.

3. Sit in a chair. Pull your toes up tight to your thigh muscle and then straighten out your knee. Hold for five seconds and then slowly relax your leg. Repeat 5- 10 times.

4. Standing with support at a table or counter, lift your leg by bending your hip and knee. Try to control the movement from your hip. Progress by increasing the number of repetitions and the height of the lift as you feel comfortable to do so.

5. Stand next to a table or counter which you can use for support. Keep your operated knee straight and lift your leg out sideways and away from your body. Keep your toes forward and do not raise your hip or pelvis when doing this exercise.



6. Standing with support at a table or counter, keep your operated knee straight and take your leg backwards. Keep your back and body straight and avoid leaning forwards when doing this exercise. You should also squeeze your buttock muscles together on the backward motion.

Hip precautions

There are certain movement and activities that we recommend that you do not perform until three months after your operation. This is to reduce the risk of dislocating your new hip, while the muscles around your hip are healing.

1. **Do not bend your operated hip past 90 degrees (a right angle)**

2. **Do not turn your operated hip inwards or twist it**

3. **Do not cross your legs or your ankles**

Activities of daily living

It is recommended that you sleep on your back for the 12 weeks after the operation. If you find this uncomfortable you can sleep on your side with pillows between your legs.

Bed transfers

- To get onto the bed, slide backwards as far as possible before moving your legs round onto the bed.
- You can use your hand under your thigh to help if needed
- Do not let your legs cross the midline, or twist and turn
- Before going home a member of the physiotherapy or occupational therapy teams will review getting in and out of bed, onto the side normally sleep on at home

Chair transfers

- When standing up and sitting down, keep the leg that was operated on forwards (knee lower than hip)
- Use the arm rests of the chair to help you, or push up from the base of the chair. Continue to get up like this for the first few weeks after you go home
- Gradually stand and sit more normally (without the leg that was operated on out forwards). You should make sure you do not force your hip movement to do this. Avoid sitting on anything low.

Toilet transfers

- If you attended the joint school, you will have been given a raised toilet seat or the right toilet equipment for use at home for the first six weeks.
- If you could not attend the class, a member of the occupational therapy team will assess you for toileting equipment while you are still on the ward
- When standing up and sitting down, keep the leg operated on out forwards (knee lower than hip)

Getting in and out of a car and driving

You should be able to go home from hospital as a passenger in a car. You will not be able to drive your car for six weeks after surgery. You should seek medical advice before trying to drive your car. It is important to try and get out of the house. Being a passenger in a car is a good way to do this.

When getting into or out of the car as a passenger:

- Always sit in the front passenger seat
- Have someone move the seat back as far as possible and recline the back
- Open the car door fully and place an extra cushion on the seat if the seat is too low
- Make sure you are on the road, level with the car and not stood on the pavement
- Back up to the car seat so you are facing outwards
- Make sure your hands are placed safely for support, using the dashboard or open window frame and the backrest of the front seat.
- Sit down as if you were sitting on a chair, by sliding the leg that has been operated on forwards.
- Slide backwards first before moving your legs one at a time. Putting a plastic bag on the seat may help, although you should make sure you take it out before setting off.

- You might require assistance to lift the leg that has been operated on into the car
- Remember to keep the leg that has been operated on in a safe position. Do not cross the midline of your body or bend your hip too much
- Once sitting in the car, the backrest can be brought up to a comfortable position. Keep your legs fairly straight to avoid bending the leg that has been operated on or knee too much.
- Getting out is the reverse of above. You should make sure the leg is out in front of you before standing up to prevent too much bend of the hip.

Important considerations before your procedure

Planning ahead

Getting the full benefit from a hip replacement can take several months and during this time many people find normal activities more challenging. This may include bathing, shopping, laundry, cooking and housework. You may need some help to do these. It is important to plan ahead and think about the support you will need when you go home. You will usually go home around three days after your surgery.

There are certain things that you can do to help you recover as quick as possible. These are:

- **Stopping smoking**: If you are a smoker it is advised you to stop or cut down prior to your surgery. Smoking can affect wound healing and delay your recovery. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0169.
- **Maintaining good physical health**: Activities that will increase your upper body strength will improve your ability to use a frame or crutches after your operation.
- **Exercises**: You should start doing the exercises outlined in this booklet to increase your muscle strength before surgery. It is also good practice as you will need to do these exercises daily following your hip replacement.
- **Sleeping on your back**: You should start practicing sleeping on your back as you will need to do this after your operation.

Where possible you should have someone at home with you for one or two weeks after going home. They should help you with things like cooking, personal care and shopping. You may only need them for part of the day. If you have any concerns about going home please discuss these with your GP, pre-assessment nurse or therapists at your Joint School appointment.

Other Information

Photography, Audio or Visual Recordings

As a teaching hospital we take great pride in performing scientific research and staff training. We occasionally ask for your permission to use images and recordings for your diagnosis and treatment, which will also form part of your medical record. We also ask for your permission to use these images for audit and training UK medical and other healthcare students.

You do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

All information we hold about you is stored according to the Data Protection Act 1998.

Useful contact numbers

• Whittington Hospital Switchboard	020 7272 3070
• Enhanced Recovery Nurse	Bleep 2746 (via switch) or 07919 565 930
• Orthopaedic Therapy Office	020 7288 5613
• Thorogood Ward	020 7288 5445
• Waiting List Administrators	020 7288 5861 / 5910
• British Red Cross	020 8944 0246
• Age UK, Islington	020 7281 6018
• Islington Social Services	020 7527 2299
• Haringey Social Services	020 8489 1400
• Arthritis UK	0800 5200 520

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Patient advice and liaison service (PALS)

If you have a compliment, complaint or concern please contact our PALS team on 020 7288 5551 or whh-tr.whitthealthPALS@nhs.net

If you need a large print, audio or translated copy of this leaflet please contact us on 020 7288 3182. We will try our best to meet your needs.

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