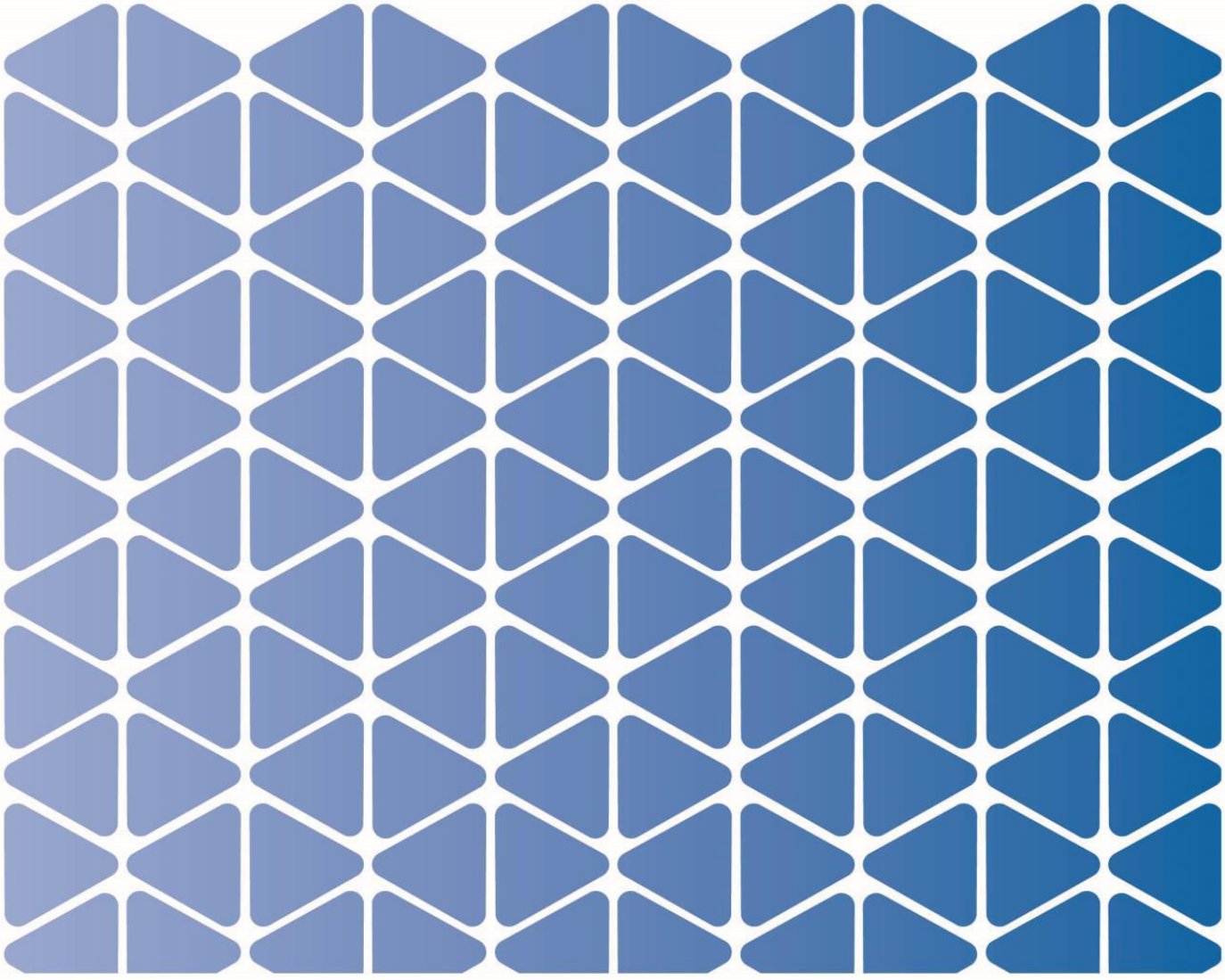
PATIENT INFORMATION

PATIENT INFORMATION FOLLOWING HIP FRACTURES

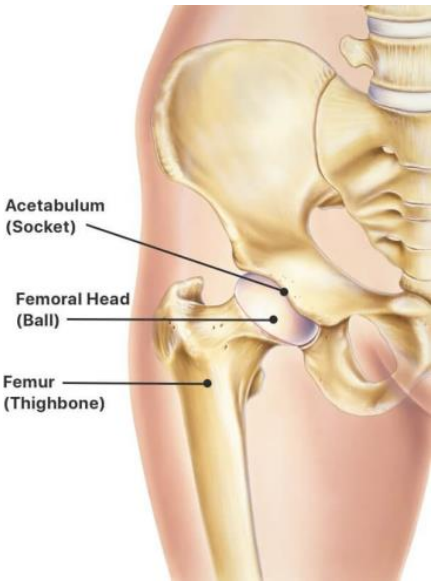


Introduction:
It has been recommended by your consultant team that you have surgery to repair a fracture (break) of your hip. This leaflet will explain what this means for you and will answer most of the questions you may have regarding your surgery, and what will happen. This will include the benefits, risk and alternatives, it aims to ensure you have all the information you need to make the right decision.

Please read the information carefully and if there is anything you are still unsure about, please ask your consultant or one of the team. You should feel like you have all the information you need.

Your time in hospital can vary, whilst you are in hospital you will encounter a lot of different professionals that make up the team. We all work together to make your experience as pleasant as possible, and to maintain high standards of care.

The hip joint and your injury:
The hip joint is a ball and socket joint made of the ball (femoral head), which sits at the top of the thigh bone (femur) and into the socket (acetabulum), which is part of your pelvis. This joint is surrounded by a fluid filled sac called a capsule. The hip can break inside the capsule (an intracapsular fracture) or outside of the capsule (an extracapsular fracture).



Causes of a hip fracture
There are many causes of fractures but usually this is due to a physical injury- for example from an accident like a fall or car crash. Excessive force will fracture any bone, however if a bone is generally weakened by disease such as osteoporosis (this makes bones thin and weak) it may fracture more easily. Hip fractures can be a result of a direct force such as a fall onto your hip or bottom; or an indirect force such as twisting the lower limb too far.

Diagnosis
You may have pain in your hip or groin area, which is worse when you move your hip joint or try to weight-bear. You may also notice that your leg seems shorter and is turning out to the side.

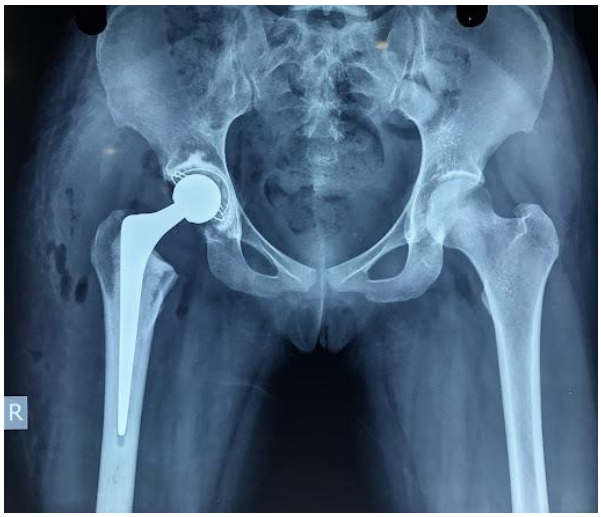
Fractures are usually first diagnosed from their symptoms, a physical examination, and by taking a patient history. The diagnosis may be confirmed with an x-ray or occasionally a CT scan.

Surgery

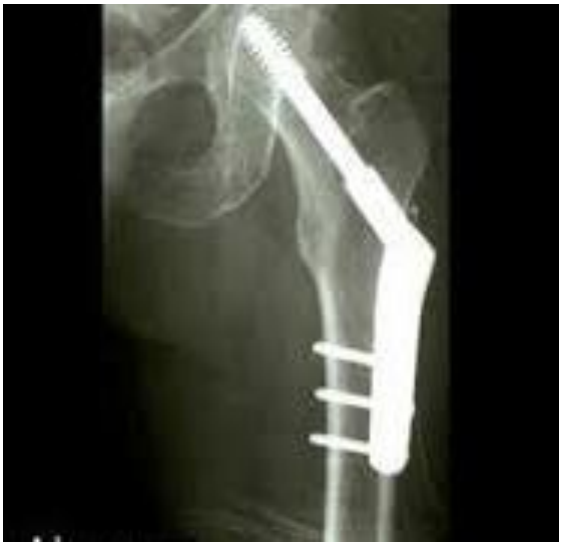
The operation you are having depends on the type of fracture that you have. It involves making an incision (cut) on the side of your thigh, just below your hip. Below the different surgeries are explained. A member of the team will inform you of which surgery you have had. If you have further questions about your surgery then please ask the surgical team.

Hemi Arthroplasty

This surgery will be performed when the head of femur (or ball) has broken off (an intracapsular fracture). It cannot be put back as it is unlikely that the bone will heal due to disrupted blood supply. The broken ball joint will be removed from your hip, and replaced by a new metal one (as shown in the picture on the right). A metal prosthesis is placed into your thighbone which acts as your new head of femur (or ball). The socket part of the joint is not damaged and therefore does not need replacing. This surgery is equivalent to half a hip replacement.



Dynamic Hip Screw (DHS)



This surgery will be performed when the fracture is outside of the capsule (an extracapsular fracture) where there is a good chance that it will heal if held in place. The internal metal work is made up of a screw placed in the head of the femur (or ball) and a plate on the side of the femur by several smaller screws (as shown in the picture on the left).

Alternative Treatments:

Your bone may heal if you remain in bed for up to 12 weeks on traction after breaking your hip. However, there is a high risk that serious, and sometimes life threatening, complications may develop such as blood clots, chest infection, pneumonia, urinary tract infections and pressure sores as a result of such a long period of bed rest.

Benefits of the procedure
The aim of your surgery is to repair your fractured hip, give you pain relief and hopefully regain some level of function and mobility.

Serious or frequent risks
Hip surgery is usually very successful with most people being happy with the outcome. However, as with all surgeries there are some risks. Surgery to repair a fractured neck of femur (hip) is a major operation and its risks are different for each individual. They will be explained to you by your surgical team.

The Risks specifically related to this surgery include problems with:

- **Infection**
    - Superficial infection- involves the surface around the scar and will need treatment with antibiotics, these may be delivered intravenously. They rarely cause serious problems unless it spreads to become a deep infection.
    - Deep Infection- This can be very serious and involves the infection of the joint itself. Dependent on when it becomes infected it may require further operations to clear the infection.

- **Loosening of the Prosthesis or metalwork –** In some cases the bone is not hard enough for the prosthesis or fixation of the device to form a secure hold. This can often result in the loosening of the prosthesis and shortening of your leg. It can cause pain in your hip and groin, and may require further surgery.

- **Blood Clots**
    - Deep Vein thrombosis- Often referred to as a DVT, this is a risk associated with any major surgery. Blood clots can form in the leg veins. To reduce this risk several measures are taken, however if this does occur you will require anti-coagulation therapy for three to six months.
    - Pulmonary Embolus- Often referred to as a PE, this is a blood clot that has travelled to your chest and lungs, and it can cause chest pains. It will also be managed with anti-coagulation for three to six months.

- **Pain-** The hip will be sore post surgery, it is important you inform staff so they can give you medicines to control the pain. This is rarely as long term problem, but occasionally surgery can fail to relieve pain.

- **Dislocation –** The ball of the femoral component can become dislodged from the hip socket. You will be shown exercises to help prevent this occurring by a Physiotherapist and an Occupational therapist will advise you of additional equipment you may find useful.

- **Nerve palsy –** During the surgery sometimes the sciatic nerve may be damaged resulting in foot drop (where it is difficult to lift your toes upwards); this is different for each individual and can be temporary or permanent. Specialist splints can be given to aid you when walking.

- **Leg length discrepancy-** It is common to have a 1/2cm difference and differences as much as 2cm are rare. Every effort is made to ensure the legs are the same length.

- **Injury to the blood vessels –** Similarly to the nerves occasionally blood vessel can be damaged, these can sometimes require a further surgical repair.

- **Keloid scar-** This occurs when the wound becomes too thickened, raised and red, and the scar can be painful.

Sometimes, more surgery is needed to put right these types of complications.

Most people will not experience any serious complications from their surgery. The risks increase for elderly people, those who are overweight and people who already have heart, chest or other medical conditions such as diabetes or kidney failure. As with all surgery, there is a risk that you may die.

You will be cared for by a skilled team of doctors, nurses and other health-care workers, who are involved in this type of surgery every day. If problems arise, we will be able to assess them, and deal with them appropriately.

Reducing the Risks

In order to reduce the risk of some of these complications, the team will encourage you to mobilise early after surgery. You may be asked to wear elasticated compression stockings on one or both legs. Sometimes you will be given some antibiotics as a precaution during or after your surgery. Stopping smoking even post surgery can help reduce these risks, as smoking can cause the wound to take longer to heal. Moving soon after your surgery with the therapy team will reduce your chance of having prolonged stiffness and pain, as well as improving your rehabilitation, and maximising the chances of getting an excellent outcome from your surgery.

Your Journey – What Happens Now?

Before Surgery

Being admitted to the ward:
You will be admitted to the ward from the accident and emergency department before your surgery. You will be welcomed to the ward, and have your details checked. We will fasten an armband containing your hospital information to your wrist. You may be asked to wear compression stockings before surgery and prior to going to theatre you will be asked to change into a hospital gown. Prior to surgery you will be looked after by a range of medical professionals including nurses and health care assistants, you will be visited by surgeons and anaesthetists to discuss your surgery.

Delays prior to Surgery:
We appreciate how upsetting it is to need to have an operation. Unfortunately trauma operations cannot be 'planned' so they take place on the 'emergency operating list'.

As other emergencies are sometimes more life threatening, and some days are extremely busy, there may be necessary delays in the time before your operation can be performed. We will try to keep you informed of any possible delays but please understand that such delays can be unexpected and unavoidable. To reduce your risk of blood clots in your legs after surgery, we will usually give you heparin or clexane injections and ask you to wear support stockings before and after your surgery. You may also have a drip inserted to give you fluids straight into your veins before your operation. We will usually ask you to continue with your normal medication during your stay in hospital. If you are on any drugs that alter your blood clotting such as Warfarin or Clopidogrel we may need to postpone your surgery until your blood clotting returns to normal. Your surgical team must ensure you are medical fit before undertaking your surgery.

Your anaesthetic visit:
There are a number of anaesthetic choices for your operation. Your anaesthetist will explain which methods are suitable for you, and help you decide which you would prefer.

They will ask questions about your general health and fitness, your past medical history, previous anaesthetics, allergies, any medicines you are taking, your dental

history and how good your neck movement is. They will explain all of the options including the risks and benefits and work with you to find your best option.

Anaesthetic options:

- **Spinal Anaesthetic** – This involves the injection of a local anaesthetic drug through a needle into the small of your back to numb the nerves from the waist down to the toes for 2 – 3 hours.

- **General Anaesthetic** – is one of the alternatives, where you are completely asleep and will feel nothing. General anaesthesia usually starts with an injection of medicine into a vein. Sometimes you will be asked to breathe a mixture of gases and oxygen through a mask to give the same effect. Once you are anaesthetised, the anaesthetist will place a tube down your airway and use a machine to 'breathe' for you. You will be unconscious for the whole of the operation and will be continuously monitored.

- **Epidural Anaesthetic** – this is similar to a spinal anaesthetic, a small tube is placed into your back near the nerves; local anaesthetic and painkillers can be given through this. It can often be combined with a spinal or a general anaesthetic and sometimes it can remain in place for 24 hours post surgery.

- **Nerve Block** – this is an injection of local anaesthetic near the nerves that go to your leg. This will numb your leg and provide pain relief for some hours after your surgery. You may not be able to move your leg properly during this time.

- **Sedation-** If you are having a spinal anaesthetic or combined spinal epidural you will not need a general anaesthetic, but we usually sedate you for this type of surgery. We will give you a sedative through a small tube (venflon) in the back of your hand. This will relax you and may make you feel sleepy.

What are the risks of anaesthetic?

Your anaesthetist will care for all aspects of your health and safety over the period of your operation and immediately afterwards. General anaesthesia is safer than it has ever been. If you are normally fit and well, your risk of dying from any cause while under anaesthetic is less than one in 100,000. This risk increases if you are older, having major surgery or have previous problems with your health.

Common side effects of having a general anaesthetic include drowsiness, nausea (feeling sick), muscle pain, sore throat and headache. Side effects of having a spinal or epidural anaesthetic are headache, low blood pressure, itching of the skin and temporary difficulty in passing urine requiring a catheter.

Rare complications of a spinal anaesthetic are temporary loss of sensation in your legs, ‘pins and needles’ or muscle weakness in your legs. Permanent damage to the nerves is very rare. We will discuss with you the risks of your anaesthetic.

Nothing to eat and drink (nil by mouth)

It is important that you follow the instructions we give you about eating and drinking. We will ask you not to eat anything for six hours before your operation (including chewing gum or sucking sweets). This is because any food or liquid in your stomach could come up into the back of your throat and go into your lungs while you are being anaesthetised.

You may drink diluted squash (not fruit juice), tea or coffee with a **small** amount of milk and water up to 2 hours before your operation.

Your normal medicines

If we do not want you to take your normal medication, your surgeon or anaesthetist will explain what you should do. It is important to let us know if you are taking anticoagulant drugs (for example, warfarin, aspirin or clopidogrel).

Getting your anaesthetic

When it is time for your operation, a member of staff will take you from the ward to the operating theatre. They will take you into the anaesthetic room and the anaesthetist will get you ready for your anaesthetic.

To monitor you during your operation, your anaesthetist will attach you to a machine to watch your heart, your blood pressure and the oxygen level in your blood.

Post Surgery

Returning to the ward:
Once the medical team are happy with your progress you will be taken from recovery back to the ward.

When you return to the ward you will rest until the effects of your anaesthetic have worn off. You may have a drip in your arm to keep you hydrated, this will be removed once you're eating and drinking normally. You may also have a catheter (a tube to your bladder to drain your urine into a bag), this will usually be removed once you are up and walking.

Pain relief after surgery
Pain relief is important as it stops suffering and helps you recover more quickly. All staff will review your pain, and work together with you to ensure it is well controlled so you can begin your rehab journey.

A range of tablets, suppositories, or injections will be used to make sure you have enough pain relief. Nursing staff will offer pain relief on regular drug rounds, but it is important for you to ask for extra if you need it. If you are struggling with pain relief you may be referred to the specialised acute pain team.

The ward staff will ask you to describe any pain you have using the following scale.

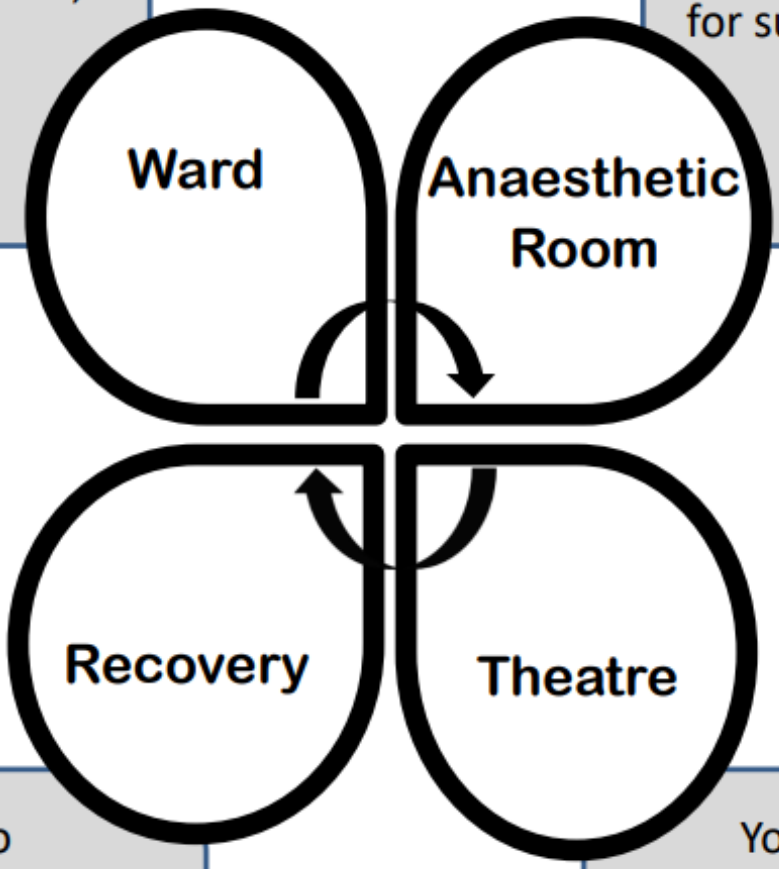
0 = No pain
1 = Mild pain
2 = Moderate pain
3 = Severe pain

It is important that you report any pain you have as soon as you experience it. You may have a PCA (patient controlled analgesia). This is a pain relief method using a machine that allows you to control your pain relief yourself. Small doses are given into a vein for immediate effect. The machine has a lock-out period so you can't overdose yourself.

Your Surgical Journey

Admitted here on day of surgery.

You will see nurses, surgeons, anaesthetist, other team members.



The anaesthetist will administer your anaesthetic to get you ready for surgery.

You will go to recovery until you're fully awake. The nurses monitor you closely until you return to the ward.

Your surgeon will complete your operation in theatre with help from specialised theatre staff.

Physiotherapy

The Physiotherapy team will generally see you on day 1 after surgery; their role is to assist you in achieving the best movement in your hip that is possible and to enable you to be as mobile as possible. Your abilities before your operation will guide this. You will be taught exercises that may help you stand up or start walking short distances if you are able to do so.

Exercises:

Deep Breathing Exercises:

To ensure your chest is clear, and to reduce the risk of a chest infection you should take 3 to 4 deep breaths every hour. Try to breathe as deeply as possible, hold your breath for 3 seconds and then slowly breathe out. After the last breath try to “huff” out the air. This may stimulate a cough. You may find your cough is productive after anaesthetic, it is important to try to cough up this phlegm to clear your chest.

Ankle Exercise:

You should pump and move your ankles in circular movements in both directions for approximately 5 minutes every hour. This will help with your circulation, and reduce the risk of deep vein thrombosis (DVT).

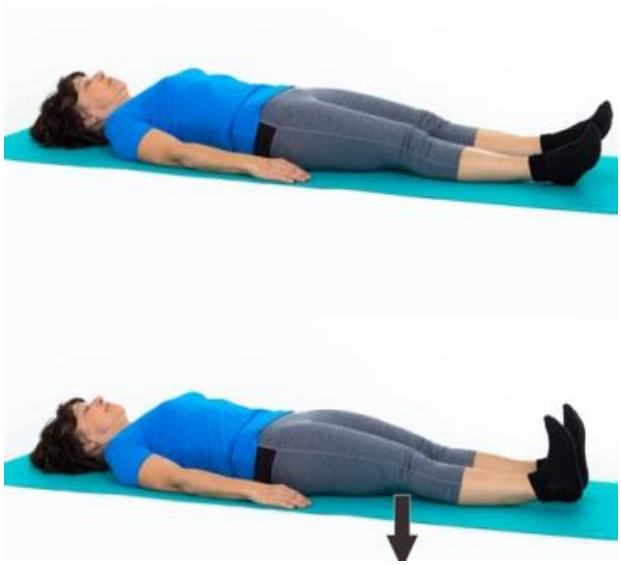
Exercise Programme

It is essential to independently practice your exercises regularly throughout the day.
It is also important to continue these exercises once you have been discharged from hospital. These exercises will aim to increase the movement and strength in your legs. It is advisable to do these exercises three times per day, if you need equipment to support don’t be afraid to ask your nursing team they are happy to help. We would recommend to do these exercises three times a day for the first three months and then three times a week for life.

Strengthening

1. Glute Squeezes- Clench your bottom cheeks firmly together. Hold for 5 seconds and relax. Repeat 10 times

2. Static Quads- Lying or sitting on the bed with your leg straight out in front of you. Tighten the muscles at the front of your thigh to press the back of your knee into the bed. Hold the tightening for 5 seconds and repeat 10 times.



3. Inner Range Quads- Lying or sitting on the bed with your legs out in front of you, place a rolled towel or a block under your knee. Keeping the back of your knee on the towel or block, straighten your knee as much as possible so your heel lifts off the bed. Hold for 5 seconds and slowly lower your heel back to the bed. Repeat 10 times.

4. Through range quads- Sitting on a chair or the edge of your bed. Lift your heel off the floor and straighten your knee. Hold for 5 seconds as straight as you can. Slowly lower your foot back to the floor. Repeat 10 times.

Hip Range of Movement

1. On the bed, with a sliding sheet under your heel, bend your hip up as far as you can, sliding your heel towards your bottom. Hold the bent position for 5 seconds and slowly straighten back out.

2. On the bed, with a sliding sheet under your heel, slide your leg out to the side as far as you can and then slide back to the midline.

Do not worry if some exercises are difficult to start with, keep trying and they will get easier. If they are very painful stop and ask for advice from your Physiotherapist.

Be careful not to overdo your exercises. Your hip will become tired and needs rest to continue healing. It is often a good idea to do your exercises about 30 minutes after you have had pain relief so that your pain is reduced.

It is recommended you avoid any extreme movements or positions that may cause you undue discomfort, such as squatting. You should only move in directions that are comfortable and do not push your hip into any positions that cause you pain.

Mobilising

You will usually begin walking the day after surgery, sometimes this is not the case, but do not worry. The Physiotherapy or nursing team will offer advice as to when you can begin walking.

When getting out of bed and walking for the first time you must wait for a member of staff, do not try this alone. The Physiotherapy or Nursing staff will assess you to decide the most appropriate walking aid to get you out of bed with. This can range from something with lots of support like a Sara Stedy (a piece of equipment that involves you standing and then sitting on a perch to be transfer into a chair) to less support such as a frame or elbow crutches.

Once the team has established the most appropriate aid for you and have ensured you have the required strength and balance, you will be shown how to walk correctly using an appropriate walking aid. Once you have been assessed by the physiotherapy team, it is important that you continue to practice walking regularly; this may be with other members of staff. The aim is to gain independence with walking with the aids as soon as possible, so you can get around the ward and to and from the bathroom on your own or with minimal supervision as soon as it is safe to do so.

Getting in and out of bed

A physiotherapist or nurse will help you get out of bed for the first time. The occupational therapist can advise you on a suitable height for your bed and chair at home. It is easier, but not necessary, to get out of bed with your operated leg first.

Standing Up and Sitting Down:

From a chair, bed, toilet etc. the advice is the same. It is more comfortable to put your operated leg out in front of you when you stand or sit. Place your hands on the arms of the chair or on the bed either side of you. Use the unoperated leg and hands to push yourself up to standing or to lower yourself back down.

Do not pull on your walking frame or have your arms through the supports of your elbow crutches to stand or sit.

If your chair does not have arms you should use this technique:

1. Position yourself sideways onto the chair, with the back of your legs touching its side. Support yourself with one hand on the back of the chair, place your operated leg out in front of you, and reach with the other hand for the seat of the chair. Lower yourself into the seated position. With both hands on the seat of the chair, pivot on your bottom, until you are facing forwards.

2. Adjust yourself into a comfortable position. Getting up is the reverse procedure.

Walking Sequence

No matter the equipment used the walking sequence remains the same, and is as follows:

1. Move walking aid forward
2. Step your operated (“bad”) leg forward
3. Step your unoperated (“good”) leg forward.

Turning round can be to either side, but you should avoid excessive twisting or pivoting on your new hip. Therefore, feet must be picked up at each step so that the operated leg is not placed too far in, or out.

As your confidence and leg control improves, you will progress from more supportive walking aids such as the pulpit or frame to those that are less supportive such as

elbow crutches or walking sticks. You should practice with these until a satisfactory walking pattern is achieved.

Most people manage with a zimmer frame, two walking sticks or crutches by the time they leave hospital. Your Physiotherapist will ensure your walking aid is correctly measured, and will issue with an appropriate aid to go home with.

Day 1

On the morning after your surgery, the nursing staff will help you wash and get dressed. They may assist you to sit out in your chair. They will administer your regular medications and any pain killers you need. The nurses will check your dressings daily.

Your consultant's team will be reviewing you regularly throughout your stay, although you will not see your consultant every day.

You will be seen by the physiotherapy team; they will teach you all of the exercises and try and get you walking.

Day 2 Onwards

The nursing staff will encourage you to get washed and dressed as independently as you can. They will help as you need it. You should practice your exercises independently and the physiotherapy team will continue to practice and progress your mobility as able. Once you are ready you will practice stairs or steps if required.

The Occupational Therapy team may see you if it is required to practice getting in and out of bed, on and off chairs and the toilet and make sure you're confident with any equipment that has been issued.

The ward Pharmacist will see you during your stay to check all of your medications are prescribed correctly for when you leave hospital. This will include your usual medications alongside any new ones required after your operation. They will be happy to answer any questions you have regarding your medication.

Stairs:

Once you are walking independently, with or without a walking aids, you may practice some steps or stairs. If you are ready to go home but are unable to do the stairs having a bed downstairs for a period of time may be advisable, this can be discussed with your therapy team. It is important to take one step at a time and that if available a handrail or bannister is used. It does not matter which side the rail is on.

Going Up

Use the rail on one side and the stick or crutch on the other;

- Step up with your unoperated leg.
- Step up with your operated leg.
- Bring your stick or crutch to the same step.

Going down

Use the rail on one side and the stick or crutch on the other;

- Put your stick or crutch down on to the next step.
- Step your operated leg down.
- Step your unoperated leg down last to the same step.

Without rails or getting up and down kerb stones

If there is not a rail or to go up or down kerbs, use the same order as above, but use both of your sticks or crutches. They should be moved in the same order.

Occupational Therapy

The role of the Occupational Therapist is to assess your ability to manage everyday activities safely and independently when at home. You will be given advice and, where necessary, equipment will be supplied. After the operation, you will temporarily need to alter the way in which you perform some daily activities; advice on this is provided below.

Leaving Hospital

Once you are feeling well and have met all of the discharge criteria you will be able to leave the hospital. There are several discharge options once you are medically fit and your team will discuss these with you.

Length of stay

How long you will be in hospital varies from patient to patient and depends on how quickly you recover from the operation and the anaesthetic. Most patients having this type of surgery will be in hospital for approximately 7 days. Many patients will require further rehabilitation assessment and care.

It is normal to have some pain once you have been discharged, ensure you take regular rest breaks and ‘paddle’ your ankles. If however your calf becomes swollen, hard, hot, red and tender, it may mean you have a blood clot in your vein and you need to contact your GP immediately.

Discharge Criteria

However long you are in hospital for, you will need to meet the following criteria before you are discharged home;

- Walk independently with an appropriate walking aid.
- Get up and down steps or stairs (if required).
- Get on and off the bed, a chair and the toilet without assistance.
- Be medically stable.
- Have made sufficient progress with moving your hip.
- Have made sufficient progress with your hip strength.
- Have all the equipment in place that you require.

If your mobility is a limiting factor depending on how much you need to progress you may be discharged to a community hospital to further progress your walking. If you have made significant progress but are needing some support with activities of daily

living such as washing or dressing you may need a temporary package of care. Your team will discuss these options with you.

Medication when you leave hospital

Before you leave hospital, the pharmacy will give you any extra medication that you need to take when you are at home for example, strong painkillers. The Trust will **not** provide any:

- Over the counter medications (i.e. simple painkillers) when you go home. Please obtain a supply for use at home.
- Additional supplies of the medicines you obtain via GP prescription. Please ensure you have sufficient supplies of these medicines.
- You will be issued with a sharps box if required, please close securely and return to the hospital when you no longer require it.

Stitches/Wound care

Wound care depends upon your surgeon preference. Your nurse will advise how long dressings need to stay on for and a supply of dressings will be given to you if needed.

Opsite dressings can be worn during showering. Do not expose the wound to water until at least 14 days post-operatively or until the wound has healed well.

Any clips or stitches that seal the wound will need to be removed after about 14 days. You may have an absorbable suture and will only require a steristrip to be removed. We will usually arrange for a community nurse to do this. The nursing staff will advise you of this before you leave.

Look out for excessive oozing, swelling, redness and warmth around the wound and any unusual or excessive increase in pain. If any of these occur and you are concerned please contact your GP surgery. You may ring the ward for advice.

A certain amount of swelling is to be expected and elevation will help relieve this. It is not recommended to use a foot stool but to lie on the bed with your whole leg supported as needed.

Compression Stockings

You must keep compression stockings on for at least six weeks after surgery. These can be taken off during the day to be washed but must be worn at night. If they begin to cause pain due to excessive swelling please contact the ward for advice.

Getting Dressed
You may find it difficult to reach your feet after the operation, the occupational therapist will show you how to dress independently and advise you on any equipment you may require to help you with this. The upper half of your body can be dressed as usual. To dress the lower half start from a seated position on a firm chair or on your bed. You may find it easier to dress the operated leg first and
undress it last. To put on your socks, pants, stockings or shoes you will require dressing aids, which will be provided if necessary.

Personal Hygiene:
You will not be able to use the bath or shower until your wound is dry and completely healed. The time for this may vary.

Once your wound has healed, when stepping into a shower cubicle use your unoperated leg first (the same technique as when managing stairs). When using the bath it is advisable to use a 'non-slip' mat and a bath board as you will not be able to sit in the bottom of the bath initially. The Occupational Therapist will practice this with you if required.

Getting on and off the toilet
The occupational therapist will assess your ability to get on and off the toilet independently before you are discharged. Some people may require a raised toilet seat and/or a toilet frame. These can be provided for you.

Diet
You do not usually need to follow a special diet. If you need to change what you eat, we will give you advice before you go home. Some loss of appetite is common following surgery. A balanced diet high in protein is important to promote healing and restore muscle strength.

Following surgery a degree of anaemia is common, leaving you feeling tired, there is information regarding 'iron in your diet' available on the website.
It is important to also drink adequate fluids and this can help reduce constipation.

General Household Activities
We recommend that you only do light household duties for the first three months. In the kitchen cook on the top of your cooker – not the oven as this requires lifting hot things out with both hands. Use the grill and microwave oven if you have one. Move around the kitchen with your walking aids or with a stick in one hand and your other hand supported on the work surface. It is important for someone to do your shopping for you until you are fully mobile. Do not lift heavy bags. You should aim to spread your

household chores evenly throughout the week and allow yourself plenty of time to rest. You should avoid heavy activities such as using the vacuum for the first six weeks after leaving hospital.

Light exercise and hobbies

After you leave hospital you can take regular short walks on even ground – gradually building up the distance you go. After approximately 12 weeks you may be able to return to hobbies such as light gardening, dancing and golf. You may also begin exercise classes again, letting your instructor know that you have had a hemi arthroplasty. All should be done in moderation without excessive effort. Your consultant will advise you on sporting activities. We recommend that you avoid strenuous exercise and heavy lifting for at least 12 weeks.

Sex

Unless you have pain, or advice to the contrary from your Consultant, sexual intercourse can be resumed six to eight weeks after your operation.

Car Driving or being a passenger

You should not drive until you feel confident that you could perform an emergency stop without discomfort – probably at least 6 to 8 weeks after your operation. It is your responsibility to check with your insurance company. When getting out of a car make sure that it is on level ground and not too near the kerb.

The passenger seat should be moved back as far as possible:

1. Ensure you are on a level to start with and not too near the kerb.
2. Position yourself sideways onto the car, with the back of your legs against the sill.
3. Reach for the back of the seat with your left hand and the seat base with your right hand.
4. Put your operated leg out in front of you, and lower yourself onto the edge of the seat. It helps if you lean back slightly.
5. Using your un-operated leg and your hands, push yourself backwards onto the driver's seat, keeping the operated leg straight in front.
6. Leaning backwards and pivoting on your bottom slide your legs into the car. Be careful and do not rush, ensure that you keep the operated leg straight during the movement, until you are facing forwards.
7. Adjust yourself into a comfortable position.

Getting out of the car is the reverse of the procedure.

Work

How long you will need to be away from work varies depending on:

- How serious the surgery is;
- How quickly you recover;
- Whether or not your work is physical;
- Whether you need any extra treatment after surgery.

Most people will not be fully back to work for 6 to 12 weeks. Please ask us if you need a medical sick note for the time you are in hospital and for the first three to four weeks after you leave.

Bending

Do not bend your operated hip excessively and force it beyond comfort. Instead, hold onto something solid, such as a table, window ledge or work surface, and slide you operated leg out behind. You can then go down, bending the knee of the un-operated leg.

Outpatient appointment

You do not usually need a follow-up appointment for this type of surgery. If you do require further follow up this will be arranged prior to leaving hospital, or sent to you in the post.

If your symptoms or condition worsens, or if you are concerned about anything, please call your GP, 111, or 999.

Patient Experience

We know that being admitted to hospital can be a difficult and unsettling time for you and your loved ones. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

Feedback

Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

Patient Advice and Liaison Service (PALS)

If you have any concerns or questions about your care, we advise you to talk with the nurse in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

How to contact PALS:

Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PET@nhs.net

Opening times:

The PALS telephone lines are open Monday to Thursday from 8.30am to 4.30pm and Friday: 8.30am to 4.00pm. Please be aware that a voicemail service is in use at busy times, but messages will be returned as quickly as possible.

If you are unable to understand this leaflet, please communicate with a member of staff.