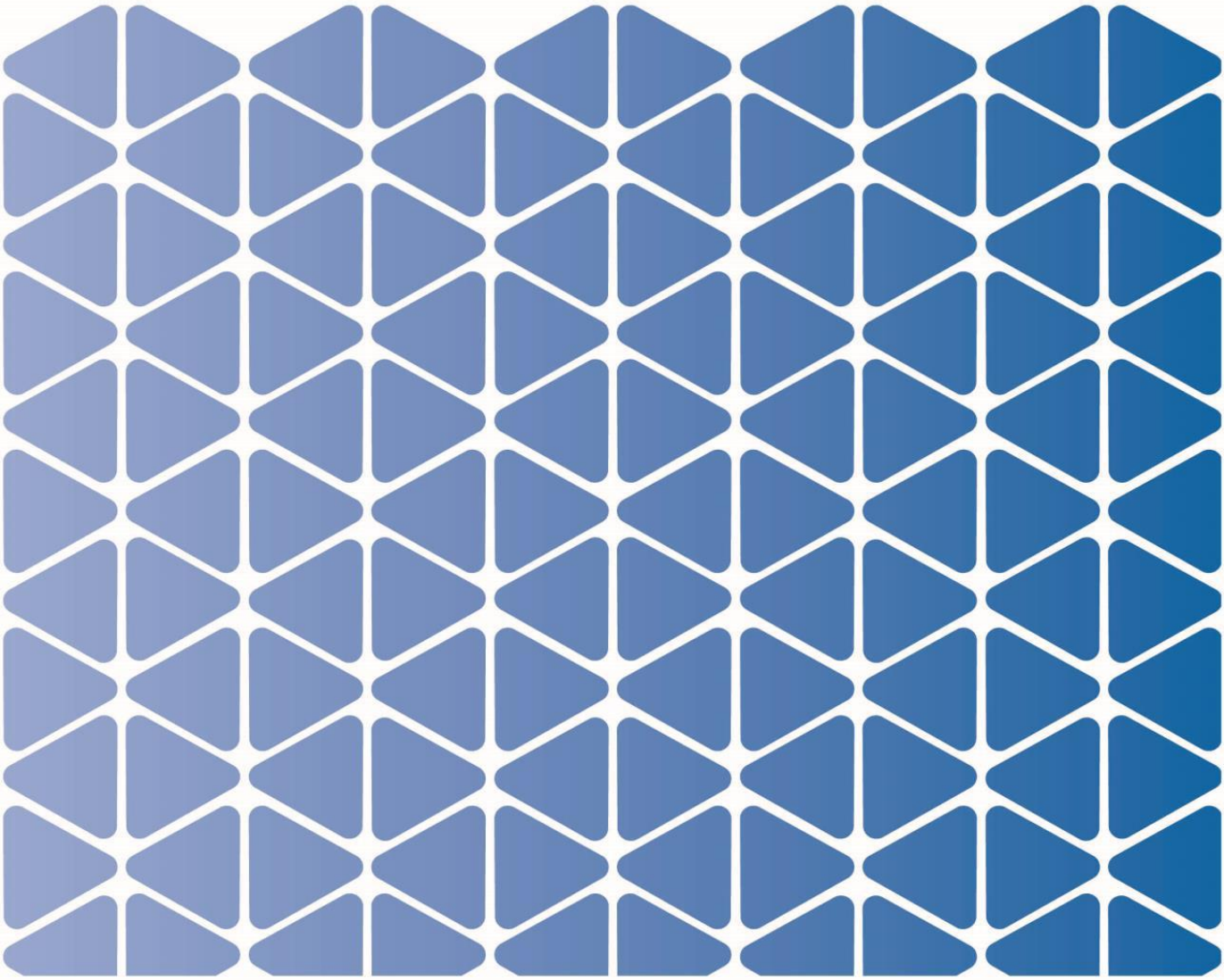
PATIENT INFORMATION

TOTAL KNEE REPLACEMENT



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It has been recommended that you have a total knee replacement.

The most common conditions, which require this operation, are osteoarthritis and the inflammatory arthropathies, such as rheumatoid arthritis. These conditions can lead to pain and loss of function of your knee. These are the most important reasons why an operation may be required. If your pain is severe enough to prevent you walking and causes you to wake up at night, then this may warrant surgery.

In assessing whether you need an operation we will ask you about activities of daily living such as putting on socks, cutting toe nails, going up and down stairs, and getting in and out of the car, as a measure of function loss. It is a combination of the above factors and how they interfere with your life that will determine the need for you to have surgery.

This leaflet explains some of the benefits, risks and alternatives to the operation. We want you to have all the information you need to make the right decision. Please ask your orthopaedic team anything you do not fully understand, or would like explained in more detail.

We recommend that you read this leaflet carefully. You and your doctor (or other appropriate health professional) will also need to record that you agree to have the procedure by signing a consent form, which your health professional will give you.

Your medical team will regularly refer to this leaflet. Please bring it with you to all of your appointments and hospital admission.

What is a total knee replacement?

The knee joint is a complicated hinge joint with various motions. It has three compartments, (medial, lateral and patellofemoral). In a younger patient, at times only one of these compartments may need to be replaced rather than a total joint replacement. 95% of the total knee knee replacements last over 10 years. There are a small number of failures, but fortunately, we have the technology to replace the artificial joint, which is either loose or infected quite successfully.

There are more than 40,000 knee replacement operations carried out in the UK each year, and this is increasing. It is designed to replace a knee joint, which is severely damaged, usually by arthritis. The joint is made up of the end of the femur (thigh bone), and the top of the tibia (shin bone) (fig 1.), and the patella (knee cap) not shown. Occasionally only a partial knee replacement is needed depending on how severe the arthritis is.

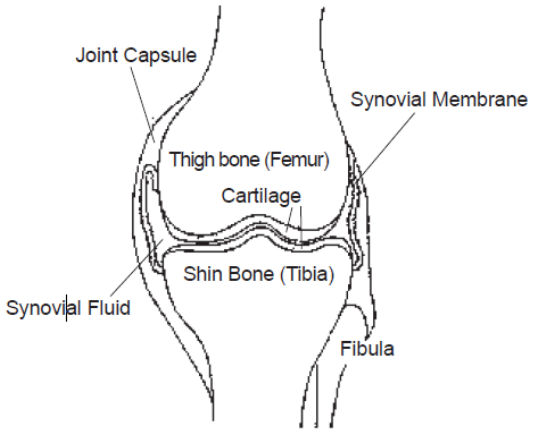
Choice of implants

The idea of improving the function of the knee joint by covering the damaged joint surfaces has been about since the 19th century but the results were disappointing. Since then scientists and clinicians have tried various ways of treating arthritic knees in order to alleviate pain and help patients to live a more comfortable life. Campbell In 1940 and McIntosh in 1958 reported successful results using metal to correct deformities, as well as covering severely damaged joint surfaces. The second line of development in knee replacement was the introduction of hinge prosthesis (artificial joint) in the 1950s which was associated with a number of failures.

In spite of that, this prosthesis served a large number of severely disabled patients with arthritic knees. Surface replacement design was introduced about 20 years ago and this has been gradually perfected ever since, so much so that the result of total knee replacements, are as good as total hip replacements. These prostheses have a very high success rate.

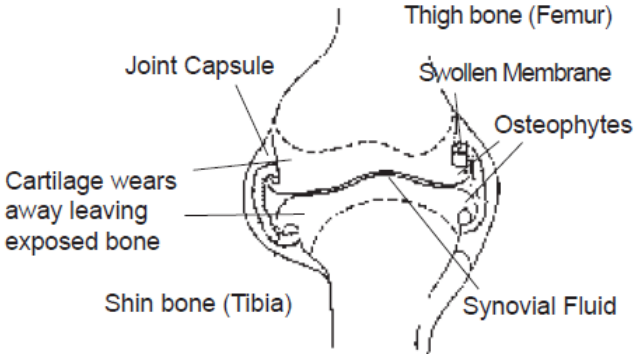
As mentioned before there are a large number of implants available, your Consultant will choose the best one that he or she is familiar with and that has the best result.

Fig. 1
Front view of knee without knee cap (patella)



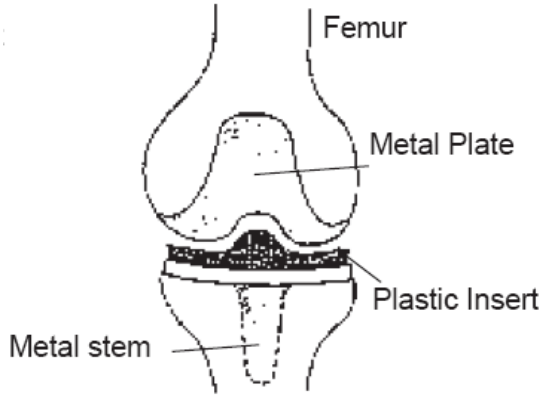
The surface of the bone is covered in cartilage material. When arthritis occurs it wears away (Fig.2) and the joint becomes rough and distorted. Movement becomes painful and restricted.

Fig. 2
Front view of
arthritic knee



The operation replaces the worn out ends of the femur and tibia with metal and plastic parts, attached separately to the femur and tibia (Fig. 3). The original patella (knee cap) is left in place but the back of the patella may be resurfaced with plastic

Fig. 3
Replacement knee joint



Benefits of the procedure

The aim of your surgery is to replace your knee joint to improve your pain and hopefully improve your mobility.

Serious or frequent risks

Everything we do in life has risks. Surgery to replace your knee joint is a major operation and there are some risks associated with it.

The general risks of surgery include problems with:

- The wound (for example, infection);
- Breathing (for example, a chest infection);
- The heart (for example, abnormal rhythm or, occasionally, a heart attack);
- Blood clots (for example, in the legs or occasionally in the lung); and
- Bleeding (in the blood vessels behind the knee).

There is a small chance you will need a blood transfusion after surgery.

Those specifically related to total knee replacement include problems with:

Complications	Risk	Explanation
Pain	(5 in 100)	The knee will be sore after the operation. If you are in pain, it is important to tell staff so that we can give you medicines to control the pain. Pain will improve with time. Rarely pain will be a chronic problem and may be due to other complications listed below or for no other reason. Rarely some replaced knees can remain painful.
Superficial infection	(5 in 100)	This means just the surface around the scar. A superficial infection will need

		treatment with antibiotics, maybe intravenously but rarely causes serious problems unless it spreads to become a deep infection.
Deep infection	(2 in 100)	Deep infection can be very serious. Many precautions are taken to prevent this complication but it still occurs. Depending when it becomes infected it may require further operations to clear the infection.
Deep vein thrombosis	(10 in 100)	As with any major surgery blood clots can form in the leg veins. Several measures are used to decrease this complication. Should this happen you will require anti-coagulant therapy for 3 to 6 months to thin your blood.
Pulmonary embolus	(2 in 100)	This is where the blood clot travels from the deep veins in your leg up to your chest. This can cause chest pain and again will require anti-coagulation for 3 to 6 months.
Not able to achieve a perfectly straight leg	(3 in 100)	Despite the best surgical techniques and careful operating, occasionally it is not possible to get the knee replacement in such a position to leave you with a perfectly straight leg. This is likely if your knee is already on an angle and can lead to pain and poor mobility. Sometimes a second operation may be necessary.
Instability	(2 in 100)	Occasionally a knee replacement may be unstable. A knee brace may be needed. A second operation may be necessary.
Stiff knee	(5 in 100)	Everybody will have a stiff knee to begin with, but some people will have long-term stiffness, and may not be able to bend their knee as much as hoped. If your knee is still stiff three months after surgery, you may have a further operation to bend your knee, with intensive physiotherapy afterwards to help improve mobility. Some people might not be able to fully straighten the knee.
'Periprosthetic' fracture	(1 in 100)	If a fracture occurs around the joint replacement, it will most likely need another operation and may lead to a poor result. This can happen at anytime during the operation, or years after.
Prosthesis wear	(1 in 100)	With modern operating techniques and new implants, knee replacements last many years. In some cases, they fail earlier. The reason is often unknown. The plastic

		bearing is the most commonly worn away part.
Nerve or vascular injury	(5 in 10,000 excluding numb scar)	Occasionally the nerve at the back of the knee can be damaged leading to weakness of the foot movements. This is usually only temporary, but rarely can become permanent. Injury to the main artery at the back of the knee is very rare but could potentially result in an amputation of the leg.

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. Approximately 1 in 2000 patients may die as a result of this type of surgery.

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.

Outcomes

Some patients find that their new knee will not bend completely. In other words, you can no longer touch your bottom with your heel. Most patients do not find this a problem. For everyday activity the range achievable is more than adequate. Kneeling may be uncomfortable but some patients manage it with time. Swelling after the operation may take several weeks to settle completely. There will be an area of numbness on the outer half of your knee, this may be permanent.

Other procedures that are available

There are a number of things that you can do to help manage your knee pain before opting for surgery:

- Take regular exercise;
- Keeping your weight down;
- Physiotherapy;
- Physical aids for example, walking stick or shock absorbing shoes;
- Take painkillers, there are also creams and gels that you could try; and
- Joint injections.

Your Consultant will discuss these with you.

How to make sure you are well prepared

Replacing a knee joint is a major operation and should not be undertaken lightly. Before your operation, it is important that you are healthy and fit. You will gain more from your new knee joint if you are prepared to put in some effort and work hard. Building up muscle strength will also help your post-operative recovery.

Diet

Before your operation it is important that you are in the best of health. To do this, it is important that you eat the correct diet. A healthy balanced diet means eating a range of bread, breakfast cereals, potatoes, pasta, rice and more fruit and vegetables.

Our pre-admission nurses will tell you if you are over weight and advise you to:

- Reduce the fat in your diet;
- Cut down on sugary foods;
- Eat more whole grain foods; and
- Keep alcohol to sensible limits.

The National Joint Registry

The National Joint Registry keeps records of all knee and hip replacement operations in England and Wales. It gives audit information about different types of joint replacement and identifies patients (should there be a need for an urgent clinical review). We will discuss this with you at your pre-operative appointment.

Medications

If you have an existing medical condition (diabetes, high blood pressure, chest or heart disease) check with your GP, well ahead of surgery, that your medication is up to date and as effective as it can be. This can help prevent delays to your surgery and gives you the best chance of your operation and recovery going well.

Exercise

Exercise is important for the following reasons.

1. It keeps joints mobile.
2. It strengthens muscles.
3. It increases circulation of the blood.
4. It improves oxygen of the tissues.
5. It increases psychological well-being.

Activity is not the same as exercise. Many people think that because they are active at home or at work that they need not carry out a specific exercise routine, but this is not the case. Never rush doing exercise, start slowly and gradually increase. Pain or uncomfortable stiffness following activity is a sign that it has been overdone. There are

some exercises that you can start with straight away whilst you are waiting for your operation. These will help to strengthen the muscles around your knee and leg and make recovery afterwards quicker and easier; they may also relieve some of your current symptoms.

Home exercises

Knee Flexion

1. Lie down on your bed as shown (you can sit up a little if you wish).
2. Slide one heal towards your buttocks bending your knee until you feel a stretch.
3. Hold for 5 seconds and relax
4. Repeat 10 times twice a day.

Thigh strengthening

1. Lie on your back (you can sit up a little if you wish) with a 5 inch roll for example, a rolled up hand towel, under your knee.
2. Raise your heel off the floor / bed until your knee is straight.
3. Hold for 5 seconds and slowly lower.
4. Do these 10 times twice a day.

Thigh strengthening

1. Sit on the edge of a chair or bed.
2. Straighten your knee fully and lift.
3. Hold for 5 seconds and relax.

Practical points

Do not worry if some exercises are difficult to start with. Keep trying and they will get easier, as mentioned previously. Stop if they are very painful.

To get up from a chair

Always put the painful leg out in front of you, push up with your hands on the arm of the chair, then use the good leg to push yourself upwards.

To sit down in the chair

Always put the painful leg out in front of you before lowering yourself into the chair.

Walking sticks

If you use a walking stick:

1. Always put the stick in the opposite hand to the bad knee.
2. Check the rubber ferrule at the end of your walking stick has not worn.
3. Check the stick is the right height – stand with your arm straight beside you, the handle of your walking stick should be level with your wrist joint. When measuring your stick you should be wearing the shoes you most often wear, no high heels please.

Sometimes it may be advisable to use two sticks instead of just one. It stops you from putting too much weight on your good leg by spreading your weight between the two.

Stairs

Going up

Practise putting your best foot first, following with the painful leg, and then your stick.

Going down

Always lead with your stick, followed by the painful leg, then your best one.

Pre-operative information group

After you have been listed for surgery you may be invited to an information class. The class includes a talk about your operation, the benefits and risks of a knee replacement, the pre-operative clinic appointment, post-operative care, physiotherapy (including pre-operative exercises) and the occupational therapy role. The class also gives you the opportunity to ask questions about your knee replacement and prepare you for surgery and discharge home.

Your pre-op assessment clinic appointment

We will ask you to go to a pre-op assessment clinic where you will see members of the medical and nursing teams of the surgical unit. The aim of this visit is to record your current symptoms and past medical history, including any medication you are taking.

It is important to let us know in the pre-op assessment clinic if you are taking:

- Anticoagulant drugs (for example, warfarin, aspirin or clopidogrel).
- Non-steroidal anti-inflammatory drugs (NSAIDs) such as Ibuprofen and Diclofenac as these may have to be discontinued before surgery.

Please bring to your pre-op assessment visit a list of the medications you are taking or have recently taken, including medicines prescribed by your family doctor and those bought “over the counter” without prescription, and also any herbal medications.

Keeping an up-to-date list of medications with you is highly recommended.

You will have a full examination and the following tests may be done:

- X-rays of your knee and chest if required;
- ECG, a tracing of your heart beat;
- Blood tests
- Urinalysis (urine test); and
- MRSA (Methicillin Resistant Straphylococcus Aureus) swabs, this is a test for bacteria that can be carried in your nose, throat and groin. It is harmless in these areas, but if it reaches an open wound, it can be very serious. It is relatively uncommon but if the test is positive you will be given a treatment pack and instructions. Your operation will be postponed until it is cleared. A patient information leaflet is available on MRSA. Please ask about this at your pre-op appointment.
- MSSA (Methicillin Sensitive Staphylococcus Aureus), this is a bacteria which may cause problems after joint replacement. If you are found to have this you will require an antibacterial body wash for 3-5 days before your operation.

The Physiotherapist and Occupational Therapist may see you at the pre-admission clinic, knee information programme, or on the ward when you arrive the day before your operation.

The members of the surgical team will check that you agree to have the planned surgery. If you have been given a consent form please bring it with you, alternatively you will be given a consent form in clinic. Make sure that you have read and understood this information before your clinic visit. If you have not understood any part of the information, you will be able to ask any questions you may have about your planned surgery.

Before you come into hospital

There are some things you can do to prepare yourself for your operation and reduce the chance of difficulties with the anaesthetic.

- If you smoke, consider giving up for several weeks before the operation. Smoking reduces the amount of oxygen in your blood and increases the risks of breathing problems during and after an operation.
- If you are overweight, many of the risks of anaesthesia are increased. Reducing your weight will help.
- If you have loose or broken teeth or crowns that are not secure, you may want to visit your dentist for treatment. The anaesthetist will usually want to put a tube in your throat to help you breathe. If your teeth are not secure, they may be damaged.

- If you have long-standing medical problems, such as diabetes, hypertension (high blood pressure), asthma or epilepsy, you should ask your GP to give you a check-up.
- If you have any cuts, grazes, ulcers or broken skin please call to inform us before you come into hospital.

Forward planning for your return home after your operation

- Forward planning ready for your return home will improve your recovery following your surgery by reducing worry.These can be discussed with the occupational therapist at the pre op assessment.

- **Shopping**

You must not lift heavy bags and carrying will be difficult whilst using a walking aid, organise some help in advance.

- **Meals**

Plan ahead, cook for the freezer or buy in ready-made frozen meals or other ready to eat meals.

- **Around the house**

Move any rugs to help prevent trips. Move regularly used objects into easily accessible places so that bending and stretching is eliminated as much as possible.

- **Housework**

Get someone else to do the heavier aspects of the housework for at least three months after you return home. Light duties are fine like dusting.

Being admitted to the ward

You may be admitted on the day of your surgery, so you and we can prepare for the surgery. We will welcome you to the ward and check your details. We will fasten an armband containing your hospital information to your wrist.

Your nurse will check your blood pressure, temperature and pulse. To reduce your risk of blood clots in your legs after surgery, we may ask you to wear compression stockings before and after your surgery.

We may give you heparin or clexane injections to reduce the risk of blood clots in your legs and your lungs after surgery (and this may continue on discharge for approximately Two weeks). Your Consultant team will discuss this with you on your admission.

We will usually ask you to continue with your normal medication during your stay in hospital, so please bring it with you.

What to bring

There is no need to remain in your nightwear all day, so you need to bring some daywear, but remember the ward is warm, so shorts / skirts and t-shirts may be all you need. You will need sensible shoes, for going home in as well as practising walking and going up and down stairs with the Physiotherapist.

Please do not bring any valuables or money with you as Worcestershire Acute Hospitals NHS Trust cannot accept responsibility for these items. Please do not wear any nail varnish, lipstick or false nails.

Mobile telephones, portable televisions and personal stereo systems without headphones must not be used in the hospital and alcohol is strictly not allowed.
The hospitals operate a no smoking policy and smoking is not permitted in any of the hospital buildings.

Your anaesthetic

We will usually carry out your surgery under a spinal anaesthetic. This will mean the lower half of your body is numbed by an injection in your lower back. We also usually give you a sedative drug by injection to help make sure that you are relaxed and comfortable during the procedure.

Alternatively, a general anaesthetic may be used for this type of operation. This means that you will be asleep during your operation and you will feel nothing.

Your pre-surgery visit by the anaesthetist

After you come into hospital, the anaesthetist will come to see you and ask you questions about:

- Your general health and fitness
- Any serious illnesses you have had
- Any problems with previous anaesthetics
- Medicines you are taking
- Allergies
- Problems with moving your neck or opening your mouth
- Any loose teeth, caps, crowns or bridges

Your anaesthetist will discuss with you the different methods of anaesthesia they can use. After talking about the benefits, risks and your preferences, you can then decide together what is best for you.

On the day of your operation

Nothing to eat and drink (nil by mouth)

Please follow the instructions we give you about eating and drinking. We will ask you not to eat or drink anything (including chewing gum or sucking sweets) for six hours before your operation. We strongly encourage you to drink water, squash or unsweetened tea coffee (with NO MORE than one fifth milk) up to 2 hours before your procedure. This prevents you getting dehydrated.

Your normal medicines

It is important to let us know, **before you are admitted**, if you are taking:

- Anticoagulant drugs (for example, warfarin, aspirin or clopidogrel).
- Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and diclofenac as these may have to be discontinued before surgery.

If you are taking other medications such as for diabetes and heart conditions these may be continued.

Also provide us, and the anaesthetist, with a list of all the medications you are taking or have recently taken, including medicines prescribed by your family doctor and those bought “over the counter” without prescription, and also any herbal medications.

Please contact your pre-op assessment clinic:

- If you are unsure which medications you must stop. If we do not want you to take your normal medication, your surgeon or anaesthetist will explain what you should do.
- If you do not feel well and have a cough, a cold or any other illness in the four weeks before you are due to come your operation. Depending on your illness and how urgent your surgery is, we may need to delay your operation as it may be better for you to recover from this illness before your surgery.

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.

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.

- A general anaesthetic
- A spinal anaesthetic
- An epidural anaesthetic
- A combination of anaesthetics

General anaesthetic

General anaesthesia usually starts with an injection of medicine into a vein. A fine tube (venflon) will be placed in a vein in your arm or hand and the medicines will be injected through the tube. You will be unconscious for the whole of the operation and we will continuously monitor you.

Spinal anaesthetic

A spinal anaesthetic involves the injection of a local anaesthetic drug through a needle into your back to numb the nerves from the waist down. During the spinal you will sit on the side of the bed or lie on your side. You will be awake during this procedure. The anaesthetic staff will support and reassure you during the procedure. As the spinal begins to take effect your anaesthetist will measure its progress and test its effectiveness. A spinal should cause you no unpleasant feelings and usually takes only a few minutes to perform. Once the injection is finished you will be asked to lie flat as the spinal works is usually effective within 10 minutes. Once the injection is working fully you will be unable to move your legs or feel any pain below the waist.

Epidural anaesthesia

This is similar to the spinal procedure. A small plastic tube is inserted into a place near to the nerves in your back. You receive local anaesthetics and pain relief drugs through this tube, relieving pain and reducing feeling in your lower body. This may be left in place for up to 24 hours after your operation to give pain relief.

Epidurals may be combined with a spinal or a general anaesthetic.

A nerve block

This is an injection of local anaesthetic near to the nerves that go to your leg. Part of your leg should be numb and pain free for some hours afterwards.

Sedation

If you are having a spinal anaesthetic 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 in the back of your hand. This is not a general anaesthetic, but will relax you and may make you feel sleepy.

Your anaesthetist will give you painkilling drugs and fluids during your operation. At the end of the operation, you will be taken to the recovery room.

Pain relief after surgery

Pain relief is important as it helps you recover more quickly.
We will usually give you tablets or injections to make sure you have enough pain relief. Once you are comfortable and have recovered safely from your anaesthetic, we will take you back to the ward. The ward staff will continue to monitor you and assess your pain relief. They 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. Sometimes patients are given a PCA (patient controlled analgesia) pump. This is a pain relief method using a machine that allows you to control your pain relief yourself.

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 (1%), 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.

After your surgery

- After your operation, we will take you to the recovery room where you will remain until you are properly awake. From there you will usually go back to the general ward. You will need to rest until the effects of the anaesthetic have passed.
- You will have a drip in your arm to keep you well hydrated. Once you are eating and drinking normally your drip may be removed.
- You may have a tube (catheter) to drain urine from your bladder into a bag next to your bed. This will usually be removed when you are ready to get out of bed and walk around.
- A nurse will check your dressing every day and will also make sure you are wearing your compression stockings correctly (if your Consultant wishes you to have them).

Exercise following your surgery

It is important to practise the exercises that you have been shown by the physiotherapist regularly throughout the day. They are designed to gradually increase the range of movement and muscle strength around your knee and prevent complications after your operation.

Exercises (Day one onwards)

1. Deep breathing exercises should be done every hour to lessen the effects of the anaesthetic and prevent chest infection.
2. Vigorous exercises of the feet and ankle should be done every hour to prevent thrombosis in the calf.
3. Tighten your thigh muscles by pushing the back of your knee into the bed. Hold for the count of four then relax. This should be done regularly to maintain the strength of your quadricep muscle.

After the operation your leg may be put on a CPM (continuous passive movement) machine. This is placed on your bed and bends your leg up and down for you. Your physiotherapist will decide when and if you need the machine and ensure a correct fit. When the dressing on your wound has been reduced your physiotherapist will apply an ice pack, usually on a daily basis. This will help reduce the knee swelling.

You should also continue with the exercises you were doing before your operation shown in this leaflet. Although you may be asked if you can do a straight leg raise (SLR), you should not do it as a regular exercise as if your knee is not completely straight, you can strain your hip or back.

Sitting

We will usually help you out of bed the day after your operation. Once you are out of bed, you must sit on a firm supportive chair. This hospital does not provide chairs for use at home, but the occupational therapist can advise you on raising your chair to the correct height if necessary. Please make sure you return your height measurement sheet to the occupational therapist.

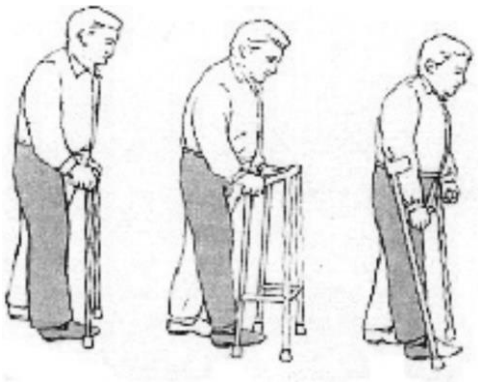
It is quite normal for your knee to be swollen for up to six months after surgery. Keep your leg elevated when sitting, and 'paddle' your ankles. If however your calf becomes swollen, hard, hot, red and tender, it may mean you have a blood clot in your vein and you need to contact your GP immediately.

Walking with your Physiotherapist

Once you have acquired balance and have become accustomed to the upright position you will begin walking, (this can be as soon as 4 hours after your surgery if you are well enough) with a walking frame to ease the weight on your 'new' knee.

The sequence is always:

1. Walking aid moved forward first.
2. Then the operated leg.
3. Finally the unaffected leg.



Turning round can be to either side, but you must prevent twisting or pivoting on your new knee. Therefore, you must pick your feet up with each step so that the operated leg is not placed to far in or out.

As your confidence and leg control improves, you will progress to walking with sticks or crutches. You should practice with these until a satisfactory walking pattern is achieved.

Most people manage with two walking sticks or crutches by the time they leave the hospital, unless there are associated problems with the other joints. Your physiotherapist will assess these problems with you.

It is important that you are measured correctly by your physiotherapist for the walking aid you are using.

How to manage stairs

- First take a step up with your healthy leg.
- Then take a step up with you affected leg.
- Then bring your stick or crutches up on the step.
- Always go one step at a time.

- First put your stick or crutch one step down.
- Then take a step down with your affected leg.
- Then take a step down with your healthy leg, onto:
- The same step as your affected leg.
- Always go one step at a time.

Leaving hospital

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 three to five days.

Medication when you leave hospital

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

- Over the counter medications (i.e. simple painkillers) when you go home. Please obtain a supply before your procedure for use at home.
- Additional supplies of the medicines you obtain via GP prescription. Please ensure you have sufficient supplies of these medicines before coming in to hospital.

Recovery

How long it takes for you to fully recover from your surgery varies from person to person,but usually It can take from six to 12 weeks. You may have family or close friends nearby who are able to support you in your home during the early part of your recovery period.

Stitches

We will take out any clips or stitches that seal the wound after about 14 days. You may have an absorbable suture and will only require a steristrip to be removed. If you have left hospital before this time, we will arrange for a community nurse to do this.

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.

Dressing
Sit down on a firm chair or bed while getting dressed. Remember to dress your operated leg first and undress it last. Do not force the knee to bend beyond discomfort.

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 un-operated leg first (the same technique as when managing stairs). When using the bath it is advisable to use a 'non-slip' mat and use the bath board that may be provided 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.

By the time you are discharged from hospital you should be able to get on and off the toilet without any assistance. If equipment is required the occupational Therapist will assess, advise and loan the equipment for up to three months after your operation.

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.

Household tasks
We recommend that you only do light household duties for the first two 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.

Light exercise and hobbies
You can return to your hobbies again for example light gardening and walking six to 10 weeks after your surgery. You may also begin exercise classes again, letting your instructor know that you have had a knee replacement. All should be done in moderation without excessive effort. Your Consultant will advise you on sporting activities.

Sex
We recommend you avoid sexual activity for the first six 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 six to eight 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 to near the kerb. It is useful to push the seat as far back on the runners as it will go to allow maximum leg room.

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; and
- Whether you need any extra treatment after surgery.

Most people will not be fully back to work for six 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.

Outpatient appointment
Before you leave hospital we may give you a follow-up appointment to come to the outpatient department, or we will send it to you in the post.

Summary and further advice

Do not:

- Twist the operated leg.
- Go on journeys for more than 30 minutes without stopping to exercise your leg.

Do:

- Take regular short walks on even ground – gradually building up the distance up you go.
- Use a walking aid for at least six weeks after your operation.
- Keep as active as you can and keep to a sensible diet.

Contact details

If you have any specific concerns that you feel have not been answered and need explaining, please contact the following.

Alexandra Hospital

- Ward 16 Staff (phone 01527 512104)

Kidderminster Treatment Centre

- Ward Nursing Staff (phone 01562 512356)

Other information

The following internet websites contain information that you may find useful.

- www.patient.co.uk

Information fact sheets on health and disease

- www.rcoa.ac.uk

Information leaflets by the Royal College of Anaesthetists about 'Having an anaesthetic'

- www.nhsdirect.nhs.uk

On-line health encyclopaedia

- www.worcsacute.nhs.uk
  Worcestershire Acute Hospitals NHS Trust

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.