Hip Fracture Program
Your complete guide to hip fracture treatment
Patient Guide
Hip Fracture Treatment
Information

Orthopaedic Surgeon ____________________________

Office Telephone ________________________________

Internal Medicine Physician ______________________

Office Telephone ________________________________

Follow-up Information

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Miscellaneous Notes

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Introduction
As the population ages, the number of hip fractures that occur each year rises. A fracture of the hip in an aging adult is not simply a broken bone. It can be a life-threatening illness. Once the fracture occurs, it brings with it all the potential medical complications that can arise when aging patients are confined to a bed. The complications are what can turn a simple break into a life-threatening illness.

At Baylor we use a team approach while caring for our patients. You are not just a statistic and will benefit from interaction with many different hospital employees. You may be seen by any of the following:

- **Orthopaedic Surgeon**—Performs surgery and directs your care, checks on you while in the hospital, and evaluates you at follow-up appointments.

- **Internal Medicine Physician**—He or she will assess and evaluate your medical needs while you are in the hospital.

- **Mid Level Providers (Physician Assistants, Nurse Practitioners and Registered Nurses)**—Assist physicians with such tasks as taking your medical history, assist during surgery, and evaluate you during your stay and at follow-up appointments

- **Anesthesia Team**—Administers your anesthesia during surgery, monitors your condition during surgery and may help with your pain management after surgery.

- **Care Coordinator/Social Worker**—Coordinates your discharge plans between your family, doctor, nursing, and physical therapy. Makes arrangements for continued care after discharge if needed, and interacts with insurance companies as needed.

- **Physical Therapy/Occupational Therapy**—Teach you exercises to increase your strength, work with you on an exercise program, instruct you on the correct way to walk and teach you daily living adjustments, which you may need to temporarily change your lifestyle following surgery.

Your daily bedside care will be provided by Registered Nurses and Patient Care Assistants.

You may also be seen by Lab personnel, Radiology personnel, Respiratory Therapy, and Chaplin Services.

Please do not be shy about asking questions and telling someone if you are feeling anxious at any time. Certainly many people will be asking you questions and talking to you about a variety of topics. Your feedback helps us plan your treatment and follow up care. Please be thorough when you answer questions from anyone caring for you. All information is strictly confidential.
Understanding Hips and Hip Fractures

To further understand how hip fractures happen it is best to understand how the hip works.

The hip joint is one of the true ball-and-socket joints of the body. The hip socket is called the acetabulum and forms a deep cup that surrounds the ball of the upper thigh bone, or femoral head. The femoral head is attached to the rest of the femur by a short section of bone called the femoral neck. The bump on the outside of the femur just below the femoral neck is called the greater trochanter. This is where the large muscles of the buttock attach to the femur.
What is a Hip Fracture?
A hip fracture is a break in the upper quarter of the femur (thigh) bone. The “hip” is a ball-and-socket joint. It allows the upper leg to bend and rotate at the pelvis. An injury to the socket, or acetabulum, itself is not considered a “hip fracture.” Management of fractures to the socket is a completely different consideration.

How Hip Fractures Happen?
Injury is an obvious cause of hip fractures. In the aging population, an injury can result from something as simple losing one’s balance and falling to the ground. While many hip fractures probably occur this way, it is also true that the fall may have happened as a result of fracturing the hip. The hip actually breaks first, causing the person to fall.

Osteoporosis is a disease in which bones become fragile and more likely to break, this can weaken the neck of the femur to the point that any increased stress may cause the neck of the femur to break suddenly. An uncertain step may result in a twist to the hip joint that places too much stress across the neck of the femur. The femoral neck breaks, and the patient falls to the ground. It happens so quickly that it is unclear to the patient whether the fall or the break occurred first. Some causes of osteoporosis may be related to:
- Aging
- Heredity
- Nutrition/Lifestyle
- Medications or other illnesses
How do doctors identify the problem?
The diagnosis of a hip fracture usually occurs in the emergency room. X-rays are typically used to determine if a hip fracture has occurred and, if so, what type of fracture it is. The orthopaedic surgeon will use the X-rays to determine if a surgical procedure will be necessary and to decide what type of procedure to suggest.

In a few cases, X-rays may not show the fracture. If the hip continues to hurt and the doctor is suspicious that a hip fracture is present a CT scan, sometimes called CAT scan is recommended. This is a noninvasive medical test that helps physicians diagnose and treat medical conditions. CT imaging combines special X-ray equipment with sophisticated computers to produce multiple images or pictures. Lastly, if needed an MRI may be done. The MRI scanner uses magnetic waves rather than radiation to take multiple pictures of the hip bones.

Tests such as chest X-rays, blood work, and electrocardiograms may be ordered to assess your overall condition.
Treatment Options

The treatment for a hip fracture begins immediately by making sure you are medically stable. Once the doctor is sure that you are stable, decisions concerning the treatment of the fracture can be made.

**Most hip fractures would actually heal without surgery, but the problem is that you would be in bed for eight to twelve weeks. Doctors have learned over the years that placing an aging adult in bed for this period of time has a far greater risk of creating serious complications than the surgery required to fix a broken hip. This is the main reason that surgery is recommended to nearly all patients with hip fractures.**

Nearly all hip fractures in the elderly are treated with some type of surgical operation to repair or replace the fractured bones. The goal of any surgical procedure to treat a fractured hip is to hold the broken bones securely in position, allowing the patient to get out of bed as soon as possible.

Prior to surgery you may be placed in traction. Traction will pull on the injured limb assisting to line up the bone fragments and provide you comfort before surgery takes place.

Many methods have been invented to treat the different types of fractures. Most hip fractures are treated in one of the following ways: with metal pins, with a metal plate and screws, metal rod and screws, or replacing the broken femoral head with an artificial implant consisting of metal and plastic.

**1. Metal Screws**
Fractures that occur through the neck of the femur, if they are still in the correct position, may require only two or three metal pins to hold the two pieces of the fracture together. This procedure, called hip pinning, allows patients to begin putting weight on that leg right after surgery.
2. Metal Plate and Screws
Some hip fractures occur below the femoral neck in the area called the intertrochanteric region. These fractures are called intertronchanteric hip fractures. These hip fractures are usually the result of a fall and often are the hardest type of fracture to treat. They often involve more than one break. As a result, several pieces of broken bone must be held together. A combination of a plate on the outside of the bone and a large screw are used to hold the pieces in place.

3. Intramedullary Nail
A combination of a rod on the inside of the bone and a large screw are used to hold the pieces in place. This procedure allows you to begin putting weight on it right after surgery.

4. Artificial Replacement of the Femoral Head (Hemiarthroplasty)
When the hip fracture occurs through the neck of the femur and the ball is completely displaced, there is a very high chance that the blood supply to the femoral head has been damaged. Most surgeons will recommend removing the femoral head immediately and replacing it with an artificial femoral head made of metal. This operation is called a hemiarthroplasty. (Hemi means half, and arthroplasty means artificial joint.) The procedure is called hemiarthroplasty because only half of the joint is replaced. The socket of the hip joint is left intact.
Pelvic Fractures

The pelvis is a ring-like structure of bones at the lower end of the trunk. The two sides of the pelvis are actually three bones (ilium, ischium, and pubis) that grow together as people age. Strong connective tissues (ligaments) join the pelvis to the large triangular bone (sacrum) at the base of the spine. This creates a bowl like cavity below the rib cage. On each side, there is a hollow up (acetabulum) that serves as the socket of the hip joint.

Unlike hip fractures, most pelvic fractures do not require surgery. They usually heal on their own. Patients with pelvic fractures are usually treated with pain medication and short periods of bed rest, followed by physical therapy. Physical therapy usually consists of walking with a walker for about four to six weeks or until the pain subsides.

Although the treatment options with a pelvic fracture are different, most being non operative, the expectations and recovery are similar to that of a hip fracture.
Having Orthopaedic Surgery

As a patient undergoing orthopaedic surgery at Baylor University Medical Center, we want your experience to be as stress-free as possible. This booklet will explain the procedures, equipment, the operation, as well as the pre-and post-operative care. When you know what to expect and when to expect it, you are less likely to feel anxious.

We individually plan your care, and then adjust it according to your needs. Furthermore, by the time you leave the hospital, you will know how to better help yourself during your recovery process.

Before Surgery
Prior to your operation, hospital protocol requires that each patient sign a consent form for anesthesia and surgery. Please try to have all your questions answered about your surgery and anesthesia before it is time to sign the consent forms.

The Operating Room
The OR holding area is a busy, active place. When you arrive an OR nurse will ask your full name and date of birth to confirm that it matches your identification bracelet. The nurse will explain what is happening and you may also answer questions if you have any concerns.

In the OR you will be moved to the operating table once you are asleep. You may notice that the room is brightly lit. Doctors, nurses, and other OR staff will be preparing for surgery and talking with you. At this time if your IV has not been started it will be. Both the surgeon and the anesthesiologist will talk with you before the procedure begins.

Waking up from Surgery
Following surgery you will go to the recovery room or PACU, post anesthesia care unit. There, a nurse will be monitoring you closely. Other recovering patients will be around you and you may hear sounds from monitors and other machines.

You may be sleepy and confused upon waking up because the anesthesia has not completely worn off. You may feel yourself drifting in and out of sleep as you slowly become more alert. Opening your eyes may be hard at first. Your incision will probably feel uncomfortable and your throat may feel sore. Your nurse may give you pain medication to make you more comfortable.

Some anesthesia gases may remain in the lungs after surgery. Deep breathing is crucial for expanding and clearing the lungs. You may also find that fluid or mucus may collect in the lungs during surgery, coughing is the best way to get rid of it, after taking three deep breaths cough several times as hard as you can. Do not be discouraged if this is difficult at first.
What to Expect Following Surgery

The aim of most surgical procedures for a fractured hip is to help people get moving and walking as quickly as possible.

A physical and or occupational therapist usually works with patients in the hospital soon after surgery. You may be assisted from your bed to a chair during the day. You may begin walking with a walker or crutches, practice dressing, accessing the bathroom, and start doing exercises to tone the muscles around the hip and thigh and to prevent the formation of blood clots.

The amount of weight that can be placed on the operated leg depends on the type of surgery performed. Most patients are able to start full weight bearing right away after surgery. Depending on the severity of the fracture, you may only be able to place partial weight down right after surgery.

### Pain Management

The incision area may burn and you may feel stiff but as soon as your body heals you will increasingly feel more comfortable. Pain medication may be given by injecting it into your IV, using a PCA, (patient controlled analgesia), or in pill form.

Do not hesitate to ask for pain medication at the first sign of discomfort. The nurse will frequently ask you what your pain level is at, 0 being no pain and 10 being the worst possible. Asking for the medication is better than letting the pain become more severe. If it is too soon for more medication the nurse may change your position, turn your pillow, or try other alternatives to make you comfortable until it is time for your next dose of pain medication.

Pain medication may not completely stop the pain but will help take the edge off.

### Blood Transfusions

There is a chance of needing a blood transfusion during or after your surgery based on several factors. Your blood will be drawn to see what your red blood cell count is, and if it is low a transfusion may be needed.
Common Problems

Most of the issues that occur after a hip fracture result from having to put an aging adult on bed rest. These can include:

- Pneumonia
- Pressure ulcers (Bed Sores)
- Deep Vein Thrombosis (DVT/Blood Clots)
- Urinary Tract Infection (UTI)
- Mental confusion

Getting you out of bed and moving can reduce the risk of developing all these complications. If an operation is necessary to stabilize the fracture and you can get out of bed quickly, this will actually reduce the overall risk of developing these complications. That does not mean that the complications may not still occur after surgery, but they are far easier to treat if you can be mobil.

Pneumonia

Bed rest can increase the risk of developing pneumonia in older patients. If anesthesia is required for surgery, the risk is even greater. After any injury that requires bed rest, you will need to do several things to keep your lungs working their best. Your nurse will coach you to take deep breaths and cough frequently.

Getting out of bed, even upright in a chair, allows the lungs to work much better. Once you have been cleared to do so, you will be allowed to sit in a chair.

The hospital’s respiratory therapists have several tools to help maintain optimal lung function. The incentive spirometer is a small device that measures how hard you are breathing and gives you a tool to improve your deep breathing. If you have any other lung disease, such as asthma, the respiratory therapist may also use medications that are given through breathing treatments to help open the air pockets in the lungs.

Pressure Ulcers (Bedsores)

Hip fractures cause pain when you move, even in bed. As a result, you stop moving around to shift your weight from time to time as you normally would. When you are lying down, there is pressure on the skin in certain areas. This pressure actually stops the blood flow to the skin by closing off the blood vessels that go to that area. Usually this is not a problem because you soon shift your weight, moving the pressure to another area. This shifting of the pressure allows the blood flow to return to the area of skin and prevents any damage.
But if something prevents you from shifting and the pressure stays constant in one area, that area of skin may eventually become damaged due to lack of blood flow. This damage is called a pressure ulcer or bedsore. The pressure causes the skin to actually die, similar to skin that has been burned with heat. First the area hurts, then it begins to blister, and then it turns into an open sore. These sores are difficult to heal if they are large. They may actually require a skin graft. They can become infected, causing other problems.

The best treatment is to prevent bedsores in the first place. Hospitals use special mattresses to help distribute weight evenly in people who must be confined to bed. Nurses also routinely move patients in bed to make sure the skin is not getting too much pressure in one area. Still, the best way to prevent pressure ulcers is to get you out of bed and moving when cleared to do so.

**Deep Vein Thrombosis (DVT)**

Deep Vein Thrombosis (DVT) can result from bed rest and inactivity. DVT occurs when blood clots form in the large veins of the leg. This may cause the leg to swell, become warm to the touch and painful. If the blood clots break apart, they can travel to the lungs, where they lodge in the capillaries (smallest blood vessels in the body) and cut off the blood supply to a portion of the lungs. This is called a pulmonary embolism. (Pulmonary means lung, and embolism refers to a fragment of something traveling through the blood vessels.)

There are many ways to reduce the risk of DVT, but probably the most effective is getting you moving as soon as possible.

Other commonly used preventative measures include:

- Pressure stockings to keep the blood in the legs moving
- Medications that thin the blood and prevent blood clots from forming
- Foot or leg pumps to manually pump the blood through your legs

**Urinary Tract Infection (UTI)**

A urinary tract infection is an infection that begins in your urinary system. Your urinary system is composed of the kidneys, ureters, bladder, and urethra. Any part of your urinary system can become infected, but most infections involve the lower urinary tract—the urethra and the bladder.

Women are at greater risk of developing a urinary tract infection than are men. A urinary tract infection limited to your bladder can be painful and annoying. However, serious consequences can occur if a urinary tract infection spreads to your kidneys.
A catheter may be placed in your bladder while you are limited to bed; this will be removed as soon as possible and as soon as it is safe for you to get out of the bed. Removing the catheter as soon as possible will help in the prevention of getting a UTI.

**Mental Confusion**

Aging adults who suffer a hip fracture and go to the hospital are under a lot of stress. Unfamiliar surroundings, pain medications, and the stress of the injury can lead to changes in a patient's behavior. This is sometimes called the sundowner syndrome because it seems to get worse at night. This can be very frightening to you and your family. Fortunately, it is almost always temporary. It can cause problems because you can become difficult to handle and will not follow instructions. You may try to get out of bed without assistance and can damage the hip further.

The best treatment for mental confusion is usually to get you moving and out of the hospital. Familiar surroundings, familiar faces, and activity are the best treatments. Medications are used when necessary, and it may be necessary for you to be restrained during this period so that you will not hurt yourself further.

Other medical conditions can cause confusion, and may require treatment. Usually the mental confusion is temporary and will go away in a matter of days or weeks.

### RAPID RESPONSE TEAM (RRT)

Baylor University Medical Center is committed to providing safe care throughout your hospital stay. We strive to respond promptly to every request. However, if you or your family believes emergent (serious, possibly life threatening) medical concerns are not being addressed in a timely manner, the Rapid Response Team is available to assist you.

The Rapid Response Team is composed of highly trained individuals who can assess the patient’s needs and intervene appropriately, if needed, as well as communicate your and or your family’s concerns to the health care team.

**When To Call:**

1. After a noticeable change in the patient’s condition has been reported to the healthcare provider, and the patient and or family does not believe it is being addressed.

2. If, in an emergent situation, there appears to be confusion about what needs to be done to care for the patient, or the family believes that the patient is not receiving appropriate care.

To access the Rapid Response Team, call 2-7782 (RRT2) from the room phone. The Rapid Response Team Nurse will request some information and give you time you can expect the Rapid Response Team to arrive.
Physical Therapy/Occupational Therapy

**Therapy Discharge Goals**
- Get in and out of bed without physical assistance.
- Transfer from bed to chair safely with use of walker/crutches without physical assistance.
- Walk 150 feet with walker/crutches safely without physical assistance.
- Climb and descend curb/stairs with/without rail with supervision or no physical assistance needed.

**Occupational Therapy Goals**
- Safely manage toileting with walker/crutches without physical assistance.
- Perform safe tub/shower transfer with minimal to no caregiver assistance.
- Able to dress self with minimal to no caregiver assistance using tools as needed.
- Communicate an understanding of hip precautions if applicable.

**Helpful Tips by Time of Discharge**
- Do all exercises 2–3 times a day, 10–20 repetitions each.
- Take your time when doing exercises. Slow steady repetitions are better than rushing through them.
- Do not hold your breath during the exercises. Continue with slow deep breathing.
- Choose a consistent time and place to exercise where you will have everything you need without distraction or interruption.
- Do not squat or kneel on knees until cleared by your doctor.

**Caution:** Please ask your surgeon about bending past 90°. This may need to be avoided while your hip is healing.

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**Ankle Pumps**
1. Extend your foot as far as you can with toes pointing forward.
2. Then bring your foot back in the opposite direction towards your leg. You should feel the calf muscles working.
3. Repeat 10–20 times.

**Quad Sets—Knee Pushdowns**
1. Lie on your back, press knee into bed or couch. Hold for 4–5 seconds and release.
2. You should feel the muscles on front of thigh tighten.
3. Do NOT hold your breath.
4. Repeat 10–20 times.
**Gluteal Sets—Buttock Squeezes**
2. Do NOT hold your breath.
3. Repeat 10–20 times.

**Abduction and Adduction**
1. Lie on your back with legs together.
2. Slide your operated leg out to the side. Keep toes pointed up and knee straight. Return to starting position.
3. Slide your non-operated leg out to the side. Keep toes pointed up and knee straight. Return to starting position.
4. Repeat 10–20 times.

**Short Arc Quads**
1. Lie on your back. Place a towel roll under your knee.
2. Lift foot, straightening knee.
3. Do NOT raise your thigh off the towel roll.
4. Repeat 10–20 times.

**Long Arc Quads**
1. Sit with your back comfortably against chair with feet on the floor.
2. Straighten your knee so that your leg is parallel to the floor.
3. Hold and release, returning to original position.
4. Repeat 10–20 times.

**Heel Slides**
1. Lying on couch or bed, slide the heel of your foot towards your buttocks.
2. Slide your heel to the original resting position.
3. Repeat 10–20 times.
**Hip Flexion Guide**

**Hip Flexion**
1. Holding onto a chair or other firm surface for support, begin marching in place.
2. When marching lift the legs so that the thigh is parallel to the floor and the knee is bent at least 90 degrees.
3. Repeat 10–20 times.

**Ankle Dorsiflexion—Plantar Flexion**
1. Standing, hold on to the back of a chair or other firm surface.
2. Go back on heels.
3. Return to starting position.
4. Rise up on toes.
5. Return to starting position.
6. Repeat 10–20 times.
Options for Care after Leaving the Hospital

After surgery, all patients will participate in rehabilitation to strengthen and increase mobility in their joint. Since every patient is different, the length and level of rehabilitation may vary. Your physician and family, in consultation with the health care team members, will decide which level of care is best for you.

**Skilled Nursing Facility**
A Skilled Nursing Facility (SNF) offers patients with more complex medical problems care after surgery. For instance, a patient who has diabetes or heart disease may recover more slowly than someone who has no medical problems. SNF level care is offered by a number of different facilities, and is appropriate for patients who can participate in at least one hour of rehabilitation a day. Once your doctor feels you are ready for SNF level care, your social worker will assist in making the transition.

**Acute Rehabilitation Facility**
An acute rehabilitation facility, (such as the nationally recognized Baylor Institute for Rehabilitation) is available for patients who need extra focus on rehabilitating their hip. An example would be a patient who has had a stroke in the past, and may need more directed rehabilitation. At an acute rehabilitation facility, patients must be able to participate in a minimum of three hours of therapy a day. There are several acute rehabilitation facilities in the area. Your doctor, family and social worker will work together to help you make arrangements to be admitted at the acute rehabilitation hospital that best meets your needs.

**Home Health Care**
Patients who do not have any medical conditions that make it difficult to heal often return home after their hospital stay. In this case, a nurse care coordinator will help make arrangements for home health care. Home health is a service that allows a nurse or therapist to come to your home to help with your rehabilitation. The home care nurse or home care therapist will continue the orders started by your doctor while you were in the hospital. This service will allow you to make a smooth transition back to your prior level of functioning. Home health care services are ordered for patients who are unable to leave their home for continued therapy.

**Outpatient Therapy**
If you are not home bound after discharge, or you do not reach your fullest rehabilitation potential upon completion of home health services, your physician may order therapy services in an outpatient clinic. The Baylor Rehabilitation System offers convenient access to outpatient rehabilitation services across the Dallas-Fort Worth Metroplex.
Everyday Living

Climbing Stairs: Up with the Good, Down with the Bad

Going up stairs:
1. Using the handrail for support, start by placing the non-surgical leg on the first step.
2. Bring the surgical leg up to the same stair.
3. Repeat until you reach the top.
4. DO NOT climb the stairs in a normal foot over foot fashion until your surgeon or therapist tells you that it is safe to do so.

Going down stairs:
1. Using the handrail for support, place the surgical leg on the first step.
2. Bring the non-surgical leg down to the same stair.
3. Repeat until you reach the bottom.
4. DO NOT descend the stairs in a normal foot over foot fashion until your surgeon or therapist tells you that it is safe to do so.
Getting In and Out of the Car

1. Move the front passenger seat all the way back to allow the most leg room.
2. Recline the back of the seat if possible.
3. If you have fabric seat covers, place a plastic trash bag on the seat cushion to help you slide once you are seated.
4. Using your walker, back up to the front passenger seat.
5. Steady yourself using one hand on the walker. With the other hand, reach back for the seat and lower yourself down keeping your surgical leg straight out in front of you. Be careful not to hit your head when getting in.
6. Turn frontward, leaning back as you lift your surgical leg into the car.
7. Return the seat back to a sitting position.
8. When getting out of the car, reverse these instructions.
Getting In and Out of a Chair

For the next 12 weeks, it is best to use a chair that has arms.

Getting into a chair:
1. Take small steps; turn until your back is towards the chair. DO NOT pivot.
2. Slowly back up to the chair until you feel the chair against the back of your legs.
3. Slide your surgical leg forward.
4. Using the arm of the chair for support of one hand while holding the walker with the other hand, slowly lower your body into the chair.
5. Move the walker out of the way but keep it within reach.

Getting out of a chair:
1. Position yourself near the front edge of the chair.
2. Place one hand on the arm of the chair and the other hand on the walker, then lift yourself off the chair. Be careful not to twist your body.
3. DO NOT try to use the walker with both hands while getting out of the chair.
4. Balance yourself before grabbing for the walker and attempting to walk.
**Getting In and Out of the Bathtub**

**Getting into the bathtub using a bath seat:**
1. Always use a rubber mat or nonskid adhesive strips on the bottom of the bathtub or shower stall.
2. Place the bath seat in the bathtub facing the faucets.
3. Back up to the bathtub until you can feel the bathtub. Be sure you are in front of the bath seat.
4. Reach back with one hand for the bath seat. Keep the other hand on the walker.
5. Slowly lower yourself onto the bath seat, keeping the surgical leg out straight.
6. Move the walker out of the way, but keep it within reach.
7. Lift your legs over the edge of the bathtub, using a leg lifter for the surgical leg, if necessary.
8. Keep your incision dry until the staples are removed.

**Getting out of the bathtub using a bath seat:**
1. Lift your legs over the outside of the bathtub.
2. Move to the edge of the bath seat.
3. Push up with one hand on the back of the bath seat while holding on to the center of the walker with the other hand.
4. Balance yourself before grabbing the walker.
**Getting into Bed**

**When getting into bed:**

1. Back up to the bed and position yourself halfway between the foot and the head of the bed. If you have access from either side of the bed choose the side which will allow you to get your non-surgical leg in first.
2. Reaching back with both hands, slowly sit down on the edge of the bed. Move toward the center of the mattress. Silk or nylon bed wear, or sitting on a plastic bag may make sliding easier.
3. Once you are firmly on the mattress, move your walker out of the way, but keep it within reach.
4. Rotate so that you are facing the foot of the bed.
5. Lift your leg and pivot into the bed. When lifting your surgical leg, you may use a cane, a rolled bed sheet, or a belt to help with lifting.
6. Lift your other leg into the bed.
7. Move your hips towards the center of the bed and lay back.
Lying in Bed
When lying on your back:
1. Position a pillow between your legs when lying on your back.
2. Keep the surgical hip/leg positioned in bed so the kneecap and toes are pointed to the ceiling.
3. Avoid letting your foot roll inward or outward. A blanket or towel roll on the outside of your leg may help you maintain this position.

Getting Out of Bed
When getting out of bed:
1. If possible, exit the bed from the side that will allow you to lower your non-surgical leg first.
2. Move your hips to the edge of the bed.
3. Sit up with your arms supporting you then lower your non-surgical leg to the floor.
4. Lower your surgical leg to the floor.
5. If necessary, you may use a cane, a rolled bed sheet, or a belt to assist with lowering your leg.
6. Use both hands to push off the bed. If the bed is low, place one hand in the center of the walker while pushing up from the bed with the other.
7. Once you are up and stable, reach for the walker.
Using the Toilet

When sitting down on the toilet:
1. Take small steps and turn until your back is to the toilet. DO NOT pivot.
2. Back up to the toilet until you feel it touch the back of your leg.
3. Slide your surgical leg out in front when sitting down.
4. If using a commode with arm rests, reach back for both arm rests and lower yourself onto the toilet. If using a raised toilet seat without arm rests, keep one hand in the center of the walker while reaching back for the toilet seat with the other.

When getting up from the toilet:
1. If using a commode with arm rests, use the arm rests to push up.
2. If using a raised toilet seat without arm rests, place one hand on the walker and push off the toilet seat with the other.
3. Slide surgical hip/leg out in front of you when standing up.
4. Balance yourself before grabbing the walker and attempting to walk.
Putting on Pants
Use a “reacher” or “dressing stick” to pull on pants and underwear:
1. Sit down.
2. Attach the garment to the reacher. Position the garment by your feet.
3. Put your surgical hip/foot in first followed by your other leg.
4. Bring the reacher towards you guiding the waistband over your feet and up your legs.
5. Pull your pants up over your knees, within easy reach.
6. Stand with the walker in front of you to pull your pants up the rest of the way.

Taking off pants and underwear:
1. Back up to the chair or bed where you will be undressing. Unfasten your pants and let them drop to the floor.
2. Push your underwear down to your knees.
3. Lower yourself down onto the bed, keeping your surgical hip/leg straight.
4. With the help of the reacher, take your non surgical hip/foot out first and then the other.
5. Using the reacher can help you remove your pants from your foot and off the floor to prevent a possible trip and fall.
Putting on Socks

Use a sock aid to put on socks:
1. Sit on a chair or bed. Slide the sock onto the sock aid.
2. Hold the cord and drop the sock aid in front of your foot. It is easier to do this if your knee is bent.
3. Slip your foot into the sock aid.
4. Straighten your knee, point your toe and pull the sock on.
5. Keep pulling until the sock aid pulls out.

Putting on Shoes

Use a long-handled shoe horn to put your shoes on:
1. Sit on a chair or bed.
2. Wear sturdy slip-on shoes or shoes with Velcro® closures or elastic shoe laces. DO NOT wear high-heeled shoes or shoes without backs.
3. Use the long-handled shoehorn to slide your shoes in front of your feet.
4. Place the shoehorn inside the shoe against the back of the heel. The curve of the shoehorn should line up with the inside curve of the shoe heel.
5. Lean back, if necessary, as you lift your leg and place your toes in your shoe.
6. Step down into your shoe, sliding your heel down the shoehorn.
Guidelines for Preventing Future Falls

Falls are the leading cause of injuries to older people in the United States. The number of falls and the severity of injury increase with age. While some risk factors for falls, such as heredity and age, cannot be changed, several risk factors can be eliminated or reduced.

Falls can occur anytime, anyplace and to anyone while doing everyday activities such as climbing stairs or getting out of the bathtub. Research shows that simple safety modifications at home, where 60 percent of seniors’ falls occur, can substantially cut the risk of falling.

Eliminate all tripping hazards in your home and install grab bars, handrails and other safety devices.

Dress Appropriately

- Wear properly-fitting shoes with nonskid soles.
- Tie your shoe laces.
- Replace slippers that have stretched out of shape and are too loose.
- Use a long-handled shoehorn if you have trouble putting on your shoes.
- Avoid high heels and shoes with smooth, slick soles.
- Women who cannot find wide-enough athletic shoes for proper fit should shop in the men’s shoe department because men’s shoes are made wider.

Understand Your Medications

- Avoid excessive alcohol intake.
- Keep an up-to-date list of all medications and provide it to all doctors with whom you consult.
- Check with your doctor(s) about the side effects of your medicines and over-the-counter drugs. Fatigue or confusion increases your risk of falling.
- Make sure all medications are clearly labeled and stored in a well-lit area according to instructions.
- Take medications on schedule with a full glass of water, unless otherwise instructed.

Tips for Your Home

Protect yourself with these simple changes in furniture arrangement, housekeeping, and lighting to prevent falls.

Bedroom

- Place a lamp, telephone and flashlight near your bed.
- Sleep on a bed that is easy to get into and out of.
- Replace satiny sheets and comforter with products made of nonslippery material; i.e., wool, cotton.
• Arrange clothes in your closet so that they are easy-to-reach.
• Install a night-light along the route between your bedroom and the bathroom.
• Keep clutter off the bedroom floor.

**Living Areas**
• Arrange furniture so you have a clear pathway between rooms.
• Keep low-rise coffee tables, magazine racks, footrests and plants out of the path of traffic.
• Install easy-access light switches at entrances to rooms so you won't have to walk into a darkened room in order to turn on the light. Glow-in-the-dark switches may be helpful.
• Walk only in well-lighted rooms, stairs and halls.
• Do not store boxes near doorways or in hallways.
• Remove newspapers and all clutter from pathways.
• Keep electric appliance and telephone cords out of walkways, but do not put cords under a rug.
• Do not run extension cords across pathways; rearrange furniture.
• Secure loose area rugs with double-faced tape, tacks, or slip-resistant backing.
• Do not sit in a chair or on a sofa that is so low it is difficult to stand up.
• Repair loose wooden floorboards right away.
• Remove door sills higher than 1/2” inch.

**Kitchen**
• Remove throw rugs.
• Clean up immediately any liquids, grease, or food spilled on the floor.
• Store food, dishes, and cooking equipment within easy reach.
• Do not stand on chairs or boxes to reach upper cabinets.
• Use nonskid floor wax.

**Stairs and Steps**
• Keep stairs clear of packages, boxes or clutter.
• Light switches should be at the top and bottom of the stairs. Or consider installing motion-detector lights which turn on automatically.
• Provide enough light to see each stair and the top and bottom landings.
• Keep flashlights nearby in case of a power outage.
• Remove loose area rugs from the bottom or top of stairs.
• Replace patterned, dark or deep-pile carpeting with a solid color, which will show the edges of steps more clearly.
• Put non-slip treads on each bare-wood step.
• Install handrails on both sides of the stairway. Each should be 30 inches above the stairs and extend the full length of the stairs.
• Repair loose stairway carpeting or wooden boards immediately.

**Bathroom**
• Place a slip-resistant rug adjacent to the bathtub for safe exit and entry.
• Mount a liquid soap dispenser on the bathtub/shower wall.
• Install grab bars on the bathroom walls.
• Keep a night-light in the bathroom.
• Use a rubber mat or place nonskid adhesive textured strips on the tub.
• Replace glass shower enclosures with non-shattering material.
• Stabilize yourself on the toilet by using either a raised seat or a special toilet seat with armrests.
• Use a sturdy, plastic seat in the bathtub if you cannot lower yourself to the floor of the tub or if you are unsteady.
Glossary of Hospital Terms

**Anesthesia**
Partial or complete loss of feeling during which patient may or may not be asleep.

**Anesthetic**
Medication usually given by injection, IV (intravenous tube or small needle) or inhalation to block any sensation of pain or discomfort. General anesthetic is frequently administered during surgery. Local anesthetic may be injected into and around a specific operative area. Local anesthetic greatly diminishes trauma to nerves in and around the operative site during surgery, therefore dramatically lessening postoperative pain.

**Anesthesiologist**
A specialized physician who calculates and administers a pre-determined amount of anesthetic depending on specific data relative to the patient and his/her operative procedure. This doctor is present throughout surgery to make certain your body is constantly functioning properly.

**Anti-Embolism Reduction Devices**

*Elastic Support Stockings (TED Hose)*
Stockings which stimulate blood flow in the legs and help reduce blood clots following surgery; these are worn by both men and women.

*Foot Pumps and Sequential Compression Devices*
Automated devices designed to pump the blood from the foot and lower leg to help circulation and reduce the possibility of blood clots.

**Bladder Catheter (Foley)**
A small tube inserted into the bladder to drain urine.

**ECG or EKG (Electrocardiogram)**
A graphic recording or the heart’s activities.

**Fracture**
Condition in which a bone is cracked but not broken, it is a break in the continuity of the bone.

**Holding Area**
A room near the operating room where the patient waits before surgery.
ICU (Intensive Care Unit)
An area in the hospital for seriously ill patients requiring immediate and continuous attention.

Incision
A precision cut made in the body during an operation

Incision Drainage Tube
A tube placed in or near the incision to drain fluid from the area.

Injection
A “shot”

IV (Intravenous)
A thin needle or tube placed in a blood vein to transport liquids, medicine or nutrients into the body during and following surgery.

NPO
An abbreviation for the Latin terms, nil per os, meaning “nothing by mouth”, including food, drink, chewing gum, tobacco or other substances.

Nurse Anesthetist
A registered nurse trained to give anesthetics.

OR (Operating Room)
The specialty equipped room where surgery is performed.

PACU (Post Anesthesia Care Unit)
An area outfitted with special equipment and monitored by post anesthesia trained staff to assist patients as they wake up after surgery.

Pre-Op (Pre-Operative)
Before surgery.

Post-OP (Post-Operative)
After surgery.
PRN
An abbreviation for the Latin terms, pro re nāta, meaning “according to the circumstances.” For example, pain medicine is given PRN, or when it is needed.

PCA (Patient Controlled Analgesia)
Gives you control over any pain you may experience by pushing a button you will receive a very small dose of pain medication through your IV.

Recovery Room
Same as PACU.

Shave and Prep
The pre-op special cleansing (sterilization) or removing of hair around the operative area. Hair may be removed by shaving or using hair remover cream.

Surgeon
A doctor specially trained to perform surgery.

Vital Signs
Temperature, pulse, blood pressure and breathing rate.