EFFECTIVENESS OF VIDEO ASSISTED TEACHING MODULE ON KNOWLEDGE, ATTITUDE AND PRACTICE AMONG PATIENTS UNDERGOING TOTAL HIP REPLACEMENT

BY

Selvi . K

A DISSERTATION SUBMITTED TO THE TAMILNADU DR.M.G.R MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR DEGREE OF MASTER OF SCIENCE IN NURSING

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EFFECTIVENESS OF VIDEO ASSISTED TEACHING MODULE ON KNOWLEDGE ATTITUDE AND PRACTICE AMONG PATIENTS UNDERGOING TOTAL HIP REPLACEMENT.

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April 2012

[i]
DECLARATION

I hereby declare that the present dissertation entitled EFFECTIVENESS OF VIDEO ASSISTED TEACHING MODULE ON KNOWLEDGE ATTITUDE AND PRACTICE AMONG PATIENTS UNDERGOING TOTAL HIP REPLACEMENT IN MIOT HOSPITALS, CHENNAI is the outcome of the original research work undertaken and carried out by me, under the guidance of Prof. Mrs. S.Ani Grace Kalaimathi M.Sc (N),PGDNA, DQA, Ph.D, Principal and HOD of Paediatric Nursing, and Prof. N. Jayasri M.Sc (N), Ph.D Vice Principal and HOD of Medical surgical nursing, MIOT College of Nursing, Chennai. I also declare that the material of this has not formed in any way, the basis for the award of any degree or diploma in this university or other universities.

SELVI . K

M.Sc (N) II YEAR.
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ABSTRACT

A preexperimental study to assess the effectiveness of Video-Assisted Teaching module on knowledge, attitude and practice among patients undergoing Total Hip Replacement in MIOT Hospitals, Chennai.

The conceptual framework of the study was developed on the basis of “Kings Goal Attainment Model” (1989). An experimental research approach with preexperimental one group pre and post test design was used to achieve the objectives of the study. The present study was conducted in MIOT Hospitals at Chennai, with a sample size of 30 patients undergoing Total Hip Replacement; a non–probability convenient sampling technique was adopted. The investigator used a demographic variable Performa and a structured questionnaire on Total Hip Replacement to collect the data. The data was collected by using the questionnaire method. After the pre-test,a video-assisted teaching module was administered to patients undergoing THR and the post test was done after a week.

The demographic characteristics revealed that most of the participants were males in the age group of <50 years. It was noted that the majority of the participants 20(66.7%) had moderate knowledge and 10(33.3%) had inadequate knowledge. The overall mean knowledge score was 51.67 with a standard deviation of 8.61. The Attitude was assessed through a likert scale. In pre-test 3(10.0%) patients had poor attitude and 26 (86.7%) of them had moderate attitude. The mean pre-test attitude score was 63.20 with a standard deviation of 8.53. So the investigator’s study revealed that the most of the patients had inadequate knowledge and moderate attitude. This indicates the effectiveness of video-teaching programme on THR. The co-relation between post test knowledge, attitude and practice obtained a value of \( r=1.00 \). This is significant at \( P< 0.05 \),which shows a high correlation. This reveals that improvement in
knowledge significantly influences the attitude of the patients on THR. The study further reveals that improvement in knowledge significantly influences the attitude of the patients on THR. There was no association of demographic variables with post test attitude except gender, previous information about THR and practicing exercise. The result indicated that the video-assisted teaching method had significantly improved the level of knowledge, attitude and practice of the patients on THR.
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CHAPTER I

INTRODUCTION.

“Play is an essential to the aged as it is to the young. I count that day lost when I am not moved to tears or laughter, but more if I have not played”

-George Sheehan.

Surgery plays an important role in the treatment and rehabilitation of patients with various forms of arthritis, conditions related to trauma, and other painful conditions resulting in functional disability. Joint replacement surgery is the most common orthopedic operation performed on older adults. Significant advances in the field of reconstructive surgery have resulted in improvements in prosthetic design, materials and surgical techniques that provide significant relief of pain and deformity and improve function and joint motion.

“A degeneration or ‘wear and tear’ of articular (joint surface) cartilage usually accompanied by an overgrowth of bone (osteophytes), narrowing of the joint space, sclerosis or hardening of bone at the joint surface, and deformity in joints.”

“Avascular necrosis (also osteonecrosis, bone infarction, aseptic necrosis and ischemic bone necrosis) is a disease where there is cellular death (necrosis) of bone components due to interruption of the blood supply. Without blood, the bone tissue dies and the bone collapses. If Avascular necrosis involves the bones of a joint, it often leads to destruction of the joint articular surfaces.”

“Arthritis refers to the inflammation of a joint.” “Ankylosing spondylitis affects the cartilaginous joints of the spine and surrounding tissues. Occasionally the
large synovial joints such as hips, knees or shoulders may be involved.” Arthroplasty is the reconstruction or replacement of a joint. This surgical procedure is performed to relieve pain, improve or maintain ROM, and correct deformity.

Osteoarthritis (OA) is a joint disease where loss of cartilage in affected joints such as the knees, hips, fingers or spine causes pain and stiffness that can be disabling. In some cases, the only treatment option for OA is total replacement of the joint, known as arthroplasty. The World Health Organization (WHO) estimates that 10% of men and 18% of women 60 years of age and older suffer from OA. In the U.S., the National Hospital Discharge Survey reported that 230,000 Americans had hip replacement surgery in 2007.

Osteoporosis is a metabolic bone disease. Where there is accelerated bone loss. It affects millions of people in the US alone. It is marked by a decrease in the amount of bone tissue, producing brittle, fragile bones that can result in fracture. Normally, there is a loss of bone mass with ageing, perhaps 0.7% per year in adults. In this, the bone micro architecture is disrupted and the amount and variety of collagenous protein in bone is altered.

Hemiarthroplasty is a quick and highly standardized procedure that allows for early weight bearing and recovery. However, most patients with a hip fracture have osteoarthritis, which may necessitate secondary conversion to total hip replacement, especially in active elderly people with higher physical demands. Single stage surgery with acetabular replacement seems straightforward to avoid secondary admission to hospital and operation with its possible risks and extra costs. These potential benefits,
however, must be traded off against the potential harms of prolonged and more invasive surgery.

Total Hip Replacement (THR) has become the most common major orthopedic surgical procedure in the UK and is also one of the most successful and cost-effective operations performed at the present time (Malchau et al 1993). Total Hip Replacement has been practiced widely in the United Kingdom for more than 25 years and the overall rate of THR surgeries are increasing over time. Recent data suggest that over 34,000 THR’s are well performed by the National Health Service in England alone during the period 1996/1997. It is thought that the demand for primary THR surgery will continue to increase as disease of the hip is age–related and life expectancy is increasing.

Primary elective THR is performed for the relief of pain caused by severe primary or secondary arthritis of the hip joint. Very simply, it involves removal of the damaged hip joint and its replacement with an artificial prosthesis. This operation usually produces complete or almost complete relief of pain and results in a significant improvement in mobility, physical function and physical well being.

The artificial hip joint usually consists of a metal ball, which replaces the original femoral head, attached to a metal stem which is inserted into the medullary cavity of the proximal femur. In the 1970’s, a number of other prostheses were developed which were designed to be used without the need for bone cement. It was hoped that this would produce greater longevity of the prosthesis and remove the need for cement removal at revision. These prostheses included press-fit prostheses and threaded acetabulum components. In addition, the surfaces of the prostheses were
often coated with small beads or mesh in the hope that the patient’s bone would grow into the pores and produce firm fixation. This concept was developed further in the 1980’s with coating of the surface of the prosthesis with hydroxyapatite (HA) in the hope that this would induce bone to grow up to and closely surround the prosthesis.

Other more recent developments have been the use of ceramic materials rather than metal for the femoral head in an attempt to reduce polyethylene wear. Some surgeons have also returned to the concept of metal on metal to eliminate polyethylene wear altogether. Another concept in THR surgery has been the development of modularity which allows the metal ball, articulates with a plastic cup which is inserted into the acetabulum. For the majority of patients THRs is a successful operation, such that only 10% of patients will require revision within 10 years of the primary operation (Murray et al 1993). A study has suggested that, at 20 years, the Charnley Prosthesis has a survival of 89% (Older and Butterack, 1992).

Minimally invasive surgery (MIS) is a new technique of hip replacement introduced in 2001. Instead of making one long incision, the surgeon uses two 2-inch (5 cm) incisions or one 3.5-1/2-inch (9 cm) incision. Using newly designed smaller implements; the surgeon removes the damaged bone and inserts the parts of the new prosthesis. MIS hip replacement takes only an hour and a half; there is less bleeding and the patient can leave the hospital the next day. As of 2002, however, obese patients or those with very weak bones are not considered for MIS.

Early complications of this type of surgery, which may lead to failure, are infection and dislocation but, for many designs of prosthesis, the results in the first
five years are good although failure rates do begin to increase by ten years after the surgery. It is for this reason that long-term follow up is absolutely essential in the assessment of outcome in this type of surgery. Each year thousands of patients undergo Total Hip Replacement surgery in order to help alleviate pain associated with debilitating hip disease and other related hip problems. It is believed that the most common reason why hip replacements fail is because the bearing surface wears out causing dislocation, implant loosening, and infection. Infection may be a more common cause of hip replacement failure.

Researchers found the most common reasons for patients needing subsequent hip replacement surgery includes:

- Dislocation of the implant.
- Loosening of the implant through the blood stream.
- Infection- such as staphylococcus infections either around the time of surgery or later through the blood stream.

A successful hip replacement and rehabilitation program can help the patients to alleviate hip pain. It can help them to move better at work, play, and rest. His/her new hip can give them a quality of life which they may not have enjoyed for some time.

Need for the Study.

These days we all want to lead active lives. People in the 60+ age group want to exercise, travel, and take courses and enjoy their retirement. To live life to the fullest we need to be mobile. This desire has led to a tremendous increase worldwide
in joint replacement surgeries. Our modern patients would like a hip as good as their own, to enjoy absolutely all the activities they previously could and to get back to their usual work, recreation and sports.

Between 200,000 and 300,000 hip replacement operations are performed in the United States each year, most of them in patients over the age of 60. According to the American Academy of Orthopedic Surgeons (AAOS), only 5–10% of total hip replacements as of 2002 were in patients younger than 50. There are two reasons for this concentration in older adults. Arthritis and other degenerative joint disorders are the most common health problems requiring hip replacement, and they become more severe as people grow older. The second reason is the limited life expectancy of the prosthesis used in hip replacements. Because THR is a complex procedure and requires a long period of recovery after surgery, doctors generally advise patients to put off the operation as long as possible so that they will not need to undergo a second operation later to insert a new prosthesis.

This demographic picture is changing rapidly, however, because of advances in designing hip prostheses, as well as changes in older Americans' rising expectations of quality of life. Many people are less willing to tolerate years of pain or limited activity in order to postpone surgery. In addition, hip prostheses are lasting longer than those used in the 1960s; one study found that 65% of the prostheses in patients who had THR before the age of 50 were still intact and functioning well ever after 25 years. A larger number of hip replacements are now being done in younger patients. One expert estimates that the annual number of hip replacements in the United States will rise to 600,000 by 2015.
Worldwide, the risk of fracture of the femoral head in the first year following resurfacing is over 2 per 100 patients undergoing the surgery. Also, 3 out of every 100 patients undergoing a resurfacing will need it redone to a total hip replacement in the first 5 years following surgery. Joint Replacement has become an accepted procedure all over the world. An estimated 1.5 million joints are replaced every year, for painful arthritis of the hip. A recent concern about resurfacing is the rejection of the metal on metal implant by the patient. The cause for this is unknown and there is no test before the operation that can detect those at risk. The Australian Hip Registry puts this risk of implant rejection as being higher in women. Approximately 2 in every 100 women will reject their prosthesis in the first year and a half following resurfacing surgery.

Hip fractures have become one of the leading causes of morbidity and mortality among the older population (70-85 years of age). Hip fracture is a major public health problem and often leads to devastating consequences. Stress and immobility related to the trauma predispose the older adult to pneumonia, sepsis and reduced ability to cope with other health problems. Hip fractures are a frequent contributor to death after the age of 75 years. Approximately 50% of patients who live independently before sustaining hip fracture are unable to regain their independent lifestyle post fracture; instead they face ongoing disability and prolonged institutionalization. Given these serious consequences it is vital to detect and appropriately treat patients who develop a hip fracture.

Total Hip Replacement surgery is found to be quite effective in terms of improvement in health-related quality of life dimensions, with the occasional exceptions of the social dimension. Patients who had poorer pre-operative health-
related quality of life and poor post-operative knowledge, attitude and practice were more likely to experience less successive rate of health. Improvements in strength, balance, and coordination after a hip replacement are needed to help patients return to their daily activities and decrease their risk for falls. Researchers have previously shown that hip strength and muscle weakness persist up to 2 years after surgery. Based on the rapid recovery in the first 3 to 4 months, some patients may stop doing their exercises, which may limit their recovery and place them at risk for falls. On the flip side, some patients may be frustrated if they are not getting better faster. Additional knowledge and scientific dissemination of surgery outcomes should help to ensure better management of patients undergoing total hip replacement and to optimize the use of these procedures.

Patient says often, “Don’t let me just read it in a book or in a pamphlet or whatever. That’s all well and good, but I want to talk to somebody”. Most of the clients are having so many questions and doubts about Total Hip replacement (THR). Once patients decided to proceed with the surgery, they anticipate it with anxiety. During clinical experience in orthopedic ward the investigator observed that the patients undergoing total hip replacement were not aware about the condition and management of the THR.

Video Assisted Teaching Module regarding anatomy & physiology of Hip joint, signs & symptoms of Hip osteoarthritis, anesthesia, surgery, exercises, diet and complications after surgery will help the client to avoid fear and anxiety. The review of literature and practical experience motivated the researchers to help and equip the patients with knowledge, attitude and practice to promote speedy recovery during post
operative period and to assess the effectiveness of video assisted teaching module on total hip replacement among the patients undergoing total hip replacement. So the investigator intended to conduct a research study on this issue.

**Statement of the Problem.**

A pre-experimental study to assess the effectiveness of video assisted teaching module on knowledge, attitude and practice among patients undergoing total hip replacement in MIOT hospitals, Chennai.

**Objectives.**

- To assess the existing knowledge and attitude of the patients who is undergoing THR.
- To determine the effectiveness of video assisted teaching module on knowledge, attitude and practice on THR among patients undergoing THR.
- To correlate the post-test knowledge, attitude and practice of patients undergoing THR.
- To find out the association between selected demographic variable with the post-test knowledge and attitude score.

**Operational Definition.**

**Effectiveness:**

It refers to the effectiveness measured in terms of improvement in knowledge gained & developing positive attitude.
Video Assisted Teaching:

It refers to a video visual aid used as a teaching aid with developed instructions and teaching program, designed for the patients undergoing Total Hip Replacement regarding diet, exercise and home care management.

Knowledge:

It refers to the client’s range of information and level of understanding on Total Hip Replacement as measured by a questionnaire on knowledge.

Attitude:

It refers to the expressed beliefs and perspective of respondents regarding total hip replacement as measured by an attitude scale.

Practice:

It refers to the action of doing by the patient in the post operative period who under goes THR as measured by practice observation check list.

Patient:

It refers to the person who got admitted and undergoing Total Hip Replacement procedure.

Total Hip Replacement:

Total Hip Replacement is a surgical procedure in which the hip joint is replaced by an artificial joint.

Hypothesis

H1 - There is a significant difference between pre-test and post-test knowledge, attitude score on THR, after receiving Video Assisted Teaching among patients undergoing THR.
H2- There is a significant association between selected demographic variables with post-test knowledge, attitude and practice.

**Assumption**

- Video Assisted Teaching Module is more effective among patients undergoing Total Hip Replacement.
- Imparting knowledge pre operatively improves practice in the post operative period.
- Acquiring knowledge and practicing promotes speedy recovery.

**Delimitation**

The study is delimited to:

- Patients undergoing THR in MIOT hospitals.
- Patients in In-patient department.
- Patients in C2, C4 wards at MIOT Hospitals, Chennai.
- Data collection period is limited to 6 weeks.

**Projected Outcome**

- Video Assisted Teaching will increase the knowledge level of patients undergoing total hip replacement.
- Patient will develop positive attitude and practice which will fasten the smooth recovery in the post operative period.
- It will minimize the short and long term complications after THR.
Based upon the results of the study, the investigator can make appropriate recommendations to improve the level of knowledge of patients regarding total hip replacement by giving Video Assisted Teaching Module.
CHAPTER II.

REVIEW OF LITERATURE.

Introduction.

Review of literature helps in selecting the appropriate methodology, developing tool, analyzing data and relating the findings from one study to another, so as to establish knowledge in a professional discipline from which valid patient theories may be developed.

A literature review is a critical summary of the research on a topic of interest, often prepared to put a research problem in context or as the basis for an implementation project. Polit & Hungler (2004)

This chapter deals with the literature relevant to the topic of study. This review of literature was divided into the following sections.

Review of literature is divided into

Section I: Literature related to Total Hip Replacement.

Section II: Literature related to Video Assisted Teaching Module.

Section – I Literature related to Total Hip Replacement.

Fitzpatrick et al. (1998) discussed a recent systematic review of outcomes for primary THR found that the most favorable revision rates were for the Charnley, Exeter and Lubinus prostheses. Intermediate results were found for the Muller, McKee-Farrar and Stanmore prostheses. The least favorable rates were found for the Ring, Harris Galante, PCA and Charnley-Muller prostheses. No substantial evidence
could be found for the use of cement less prostheses in terms of independent observation of results from five or more studies.

Faulkner et al. (1998), discussed on cemented designs, in general which show good survival results at 10–15 years and beyond. Prostheses with good, published, comparable results (at 10 years or more) include the Stanmore, Howse, Lubinus, Exeter and Charnley. There is some evidence that all polyethylene acetabulum prostheses are preferable to metal-backed designs in terms of longevity of the implant. Newer (second generation) cementation techniques provide better results than traditional techniques.

Glick et al. (2009), described the use of below-knee skin traction and a series of pulleys to provide distraction. This process can be refined by using an orthopedic traction table. The use of a specialist hip distractor allows longitudinal and lateral traction to be applied in a controlled, measured and reproducible manner. Some 20 kg of traction, combined with saline distension, achieves 1.5- 3.0 cm of distraction of the hip joint.

Orthopedics study was conducted to understand patients’ perceptions regarding hip resurfacing arthroplasty relative to conventional total hip arthroplasty (THA). A consecutive group of 139 patients was evaluated for hip symptoms and asked to complete a survey regarding hip resurfacing arthroplasty. Forty-one percent were aware of hip resurfacing arthroplasty, and 82% felt hip resurfacing arthroplasty was a safer procedure than THA. Seventy-nine percent felt there was less soft tissue damage associated with hip resurfacing arthroplasty, and 80% felt they would return to their activities more quickly. Eighty percent felt that their overall range of motion would be better following hip resurfacing arthroplasty. Patients’ perceptions of hip
resurfacing arthroplasty are inconsistent with the known published advantages and
disadvantages of the procedure when compared to conventional THA. Most of the
patients received their information from sources other than an orthopedic surgeon.

J.orthop.,(2011) conducted a study on 65 patients (average age of 61 years) followed for up to 65 weeks after a Total Hip Replacement). The study determined whether people had recovered by measuring how far they could walk in 6 minutes and using what they reported about their problems in doing daily activities. Both measures were taken prior to surgery and at several points during the recovery process. The researchers found that most patients had a rapid recovery during the first 3 to 4 months after surgery, but improvements then continued at a slower rate for up to a year. These findings are important, because, if you do not see rapid improvement in the first 3 to 4 months after surgery or if you stop making progress during the first year, you may benefit from an evaluation to determine if additional exercises or other forms of rehabilitation would help your recovery.

Nilsdotter et al 2003; Knutsson and Bergbom Engberg 1999, Conducted a study, stated that THR has been identified as one of the most successful and cost-effective surgical Nursing. Studies of THR patients have also addressed cost effectiveness and quality outcome indicators, primarily focusing on clinical pathways and other strategies for improving short-term patient outcomes and reducing the length of stay. The pivotal role of nurses in effective discharge planning that can result in decreasing costs, improving patient outcomes and satisfaction, reducing readmission rates and enhancing continuity of care. The majority of researchers in this area contend that good discharge planning can help maintain continuity of care by ensuring integrated, accessible health services
George Mnatzaganian. (2007), conducted a study to demonstrate a strong inverse correlation between smoking duration and risk of total joint replacement. The researchers analyzed the medical records of 11,388 men who were followed from 1996-1999 to March 2007. During that time, 857 of the men had either total knee replacement (59%) or total hip replacement (41%). The investigators found that being overweight independently increased the risk of total joint replacement, while smoking lowered the risk. This reduced risk was most evident after 23 years of smoking, and men who smoked 48 years or more were up to 51% less likely to undergo joint replacement than men who never smoked, the study showed, about 230,000 Americans had hip replacements and 543,000 had knee replacements that year.

Koniczny P, Piechowicz J, Kotelai. (2010), has described the rules of streamlining sick after hip replacement. During patient’s stay in hospital, in every contact with the sick the nurse try to mark his psychical and psychological state. In judgment of psychical state the nurse try to tell what is the attitude of the patient to himself, to the illness, to the treatment, other patients and to medical staff. Information can help in planning an effective therapy for this patient and preparing the patient to returning home. Before leaving the hospital it is very important to prepare a patient to live with a artificial hip. To continue the therapy program (exercises), the patient should feel responsibility for success of rehabilitation. Intensive exercises are necessary according to recommendations of therapist.

Montin L, Johansson K, Kettunen J, Katajisto J, Leino-Kilpi H. et al.(2010), studied the education of orthopedic patients as an essential component of nursing, because it has been shown to have a positive impact on outcomes of care and treatment. Patients (n = 123, mean age 68 years) undergoing total hip or knee
arthroplasty was given a self-administered structured instrument, including 6 different
dimensions of knowledge. The results show that patients perceived that they received
most knowledge on the biophysiological dimension and least on the financial
dimension. Patients’ discharge destination and positive evaluation of hospitalization
were related to their perceptions of the knowledge received. Finally it is concluded
that individually tailored education is needed to meet patients’ educational needs.
Nurses have a big responsible for ensuring that patients have enough knowledge even
if they do not ask for this knowledge.

Allyson Jones et al (2001) conducted a study, compared a group of THR and
total knee replacement patients pre and post-operatively, using the SF-36 and the
Western Ontario and McMaster Universities (WOMAC) Osteoarthritis Index. They
found that although patients did not achieve the same level of overall physical health
as the general population, matched for age and gender, age was not a significant
determinant of pain or function. This lies in contrast to another Swedish study, which
used both the SF-36 and WOMAC to study THR patients prospectively, finding a
significantly high correlation between older age and poor outcome scores (including
pain) over a three year period.

Akiyama H, Yamamoton K et al. (2006), conducted a study in Kobe City
Medical Centre General Hospital, Department of Orthopedics retrospectively and
reviewed 40 hips in 36 patients who had undergone acetabular reconstruction using a
titanium Kerboull-type acetabular reinforcement device with bone allograft between
May 2001 and April 2006. Impacted bone allografts were used for the management of
Type III defects in 23 hips. This clinical study indicates that revision of total hip
replacement using the Kerboull-type acetabular reinforcement device with bone allograft veiled satisfactory mid-term results.

Zhao X Zhu ZA et al. (2008), conducted a study in the Ninth people’s hospital, Shanghai Jiao Tong University School of Medicine, China, on performing total hip replacement (THR) in high dislocate hips, the presence of soft-tissue contractures means that most surgeons prefer to use a femoral shortening osteotomy in order to avoid risk of neurovascular damage. The study reported that no loosening of the implant was observed, and no dislocations or infections were encountered. Total Hip Replacement without a femoral shortening osteotomy proved to be a safe and effective surgical treatment for high dislocated hips.

A. Ververeli, MD; Eric B. Lebby, MD et al. (2009) conducted a study on Evaluation of Reducing Postoperative Hip Precautions in Total Hip Replacement .The time-points at which the patient first drove and ambulated with a cane, without a cane, and without a limp were also collected. No incidents of dislocation occurred. Patients in the early group were faster to ambulate with only a cane (P=.03), without a cane (P<.001), and without a limp (P=.003). They also drove earlier (P=.02). Pace of recovery was the only significant difference between the 2 groups. The early rehabilitation protocol increases the pace of recovery compared to a pathway with hip precautions without increasing complications.

Clement ND, Macdonald D et al. (2006), conducted a prospective study which compared the outcome complications, and mortality of Total Hip Replacement (THR) and Total Knee Replacement (TKR) in a prospectively selected group of patients aged ≥ 80 years with that of a control group aged between 65 and 74 years. There were 171 and 495 THRs and 185 and 492 TKRs performed in the order and control groups,
respectively. No significant difference was observed in the mean improvement of oxford hip and knee scores between the groups at 12 months. The control group had significantly (P = 0.02 and P=0.04, respectively) greater improvement in the physical well being component of their SF-12 score, but the older group was more satisfied with their THR (P=0.047). The older group had a longer hospital stay for both THR (5.9 versus 9.0 days, p<0.0001) and TKR (6.2 versus 8.3 days, p<0.0001). The rates of post-operative complications and mortality were increased in the older group.

Biau D.J meziane et al. (2001), conducted a study. The purpose of this study was to define immediate post-operative ‘quality’ in Total Hip Replacements and to study prospectively the occurrence of failure based on these definitions of quality. The evaluation and assessment of failure were also based on these definitions of quality. The evaluation and assessment of failure were based on ten radiological and clinical criteria. The cumulative summation (CUSUM) test was used to study 200 procedures over a one-year period. For the CUSUM test, the level of adequate performance was set as a rate of failure of 20% and the level of inadequate performance set at a failure rate of 40%; no alarm was raised by the test, indicating that there was no evidence of inadequate performance. The use of a continuous monitoring statistical method is useful to ensure that the quality of total hip replacement is maintained, especially as newer implants are introduced.

Kristi Elisabeth Heiberg (2009) conducted a study, that patient who receives walking skills training following total hip arthroplasty for osteoarthritis show improved physical function. The physical therapy program displayed a positive effect on walking distance and stair climbing which continued 12 months following hip replacement surgery. Results show those who took part in the walking program
displayed significant improvement in physical performance measures and self-reported physical functioning at five months following surgery compared to the control group. Compared to baseline measures (3 months post surgery), 66% of subjects in the training group and 15% in the control group improved their walking distance to 164 feet (50 meters) or more by the fifth month following hip replacement surgery. At 12 months post surgery the training group showed greater improvement in walking distance and stair climbing abilities than the control group.

Malviya A. Martin. K et al. (2000), conducted that the background and purpose multimodal techniques can aid early rehabilitation and discharge of patients following primary joint replacement. They hypothesized that this not only reduces the economic burden of joint replacement by reducing length of stay, but also helps in reduction of early complications. Patients and methods were evaluated for 4,500 consecutive unselected total hip replacements and total knee replacements in relation to length of hospital stay, mortality, and preoperative complications. The interpretation of this study revealed that a substantial reduction in death rate, reduced length of stay, and reduced transfusion was found after the introduction of the multimodel enhanced recovery protocol.

**Section-II Literature related to Video Assisted Teaching Module.**

A study conducted by Dr. Latha venkatesan. (2008), at Apollo College of Nursing in Chennai, revealed that the video program on road safety was effective in bringing out the positive changes in the knowledge and attitude of school children who took part in the program. In the pre-test there was a low moderate positive correlation ($r = 0.032$) between knowledge and attitude whereas in the post-test
moderately positive correlation ($r = 0.42$) between the knowledge and the attitude was seen.

Banda et al. (2010) conducted a study of video modeling interventions to teach spontaneous requesting using AAC devices to individuals with autism, a preliminary investigation. His multiple baseline study investigated to what extent individuals with autism would learn to operate a speech generating device (SGD) to request a preferred object by observing a video model. The intervention consisted of each participant viewing a 10 to 15 video model that demonstrated the requesting of a preferred object using a SGD. After viewing the video model, two participants displayed the ability to request preferred items using the SGD without prompting cues. The study proved that the video-modeling could be used to teach individuals with autism.

Babu.(2003), indicated the effectiveness of video assisted teaching on knowledge, attitude and practice of self insulin injection procedure and the result was more significant (p<.001).

S.Sarojini, (2010) conducted a study to assess the effectiveness of video teaching vs lecture cum demonstration on antenatal examination with the sample size of 80 III year B.Sc students studying in RMCON which was conducted for four weeks and the post-test mean score in the control group was 27.775 with SD of 7.622 and the mean score in the experimental group was 36.150 with the SD of 6.491 with the P< 0.001 which shows that the student gained skill on antenatal examination after attending lecture cum demonstration and video teaching.

Wong.I.V.(2003), conducted a study stated that culturally sensitive educational video material using familiar metaphors can be shown to have a
statistically significant effect on patient’s knowledge of medication taking concepts. The success of the video has resulted in its wide spread use in ARV roll out in South Africa.

Cindy et al.(2002), conducted a study to compare the outcomes of preoperative education provided in a non-interactive versus an interactive DVD programme. An experimental design was used. Convenient sample of 58 elective joint replacement patients were selected. Subjects were randomly assigned to the video or DVD group. Measurements included post education test of knowledge, patient satisfaction questionnaire, and post discharge collection of data on physical therapy participation, complications, pain behaviors and length of stay. The participants in the DVD group had statistically higher knowledge scores and significantly more physical therapy visits.

Isarabkura-Na- Ayudhyac et al. (2010) conducted a study to examine the knowledge capacity of villagers in the klongmai, regarding diabetes by way of action research. A health status assessment and a survey of the community were carried out and used as the basis for designing an educational background. The results indicated that the devised educational materials were effective in encouraging the community’s self-awareness and perception of diabetes at the significance level of 0.05.

Brinbach et al(2002) conducted a study to assess the effectiveness of video teaching technology as the an adjunct to teach & evaluate epidural anesthesia performance skills among the second year anesthesiology residents through a
prospective randomized blind study. The researcher concluded that resident in the video improved a greater degree than resident in the non-video group.

Munikumar. (2002), found out that video modeling instruction holds good promise for application to clinical practice in facilitating knowledge acquitting reducing anxiety and improving self care behavior.

Ms.G.R.Neelimarani (2009) study to assess the knowledge gain with Video Assisted Teaching on kangaroo mother care among B.Sc Nursing III year students at NIMS College of Nursing. Total score and item wise analysis on kangaroo mother care among B.Sc nursing III year students are found to be improved (35.22) with pre test and post test scores, hence, null hypothesis is rejected and research hypothesis accepted. Effectiveness of video assisted teaching on kangaroo mother care shows, an improvement of knowledge scores with pre test and post test by using paired ‘t’ test. The 't' value is 9.6429 at 29 degrees of freedom, it shows highly positive. Hence research hypothesis (H2) is accepted and null hypothesis rejected. (H02).

Bowering et al. (2000), conducted a study to attempt to video tape preparation of patients before hip replacement surgery with the aim of reducing stress and anxiety. The use of video tape decreased anxiety and stress measured in terms video of urinary cortical excretion and intra operative systemic blood pressure in patients undergoing hip replacement surgery and prepared them to cope better with the post-operative pain.

Becker et al.(1999), supplemented by their descriptive study to compare patient recall information which nurses taught through video supplement in patients
receiving chemotherapy that this study’s interesting issue was about the feasibility of developing patients educational strategies.

Giocoma et al.(1999), investigated the effect of video teaching on renal transplant recipient outcomes among 59 adults undergoing renal transplantation, the quasi experimental study concluded the experimental group which received the use of video teaching had significantly greater improvement in knowledge scores in post teaching.

San Guipetti and Catanzares. (1998), conducted a study and the study results indicated that patient and family care givers who received a discharge teaching video tape on cognitive dysfunction were more informed and better prepared to help loved ones to compensate for cognitive dysfunction.

Weston et al. (1997), conducted a study on 90 prenatal which suggested that a patient information video combined with an information sheet may result in greater participation in a research trail and may increase women’s knowledge of a specific health problem.

Yamunavathi (2011) studied the effectiveness of Video assisted regarding congenital heart disease. The study design used was one group Pre test and post test design. The overall pretest and posttest mean knowledge score was 55% and 79.67%, the mean attitude score was 80.33% and 93.67% respectively. The t value shows that effectiveness of knowledge and attitude on video teaching programme was highly significant at P< 0.001. The educative measure showed that significant improvement in knowledge, attitude regarding care of children with congenital heart disease.
Sko. (1995), reemphasizes the need for development and use of pre operated videotaped patient education with Orem’s Self Care Deficit Theory used as a nursing theory frame work. The intervention was piloted on four subjects who expressed positive evaluation of the alternative educational strategy.

Robertson et al. (1991), suggested that video tapped behavioral treatment program consist of the positive behavioral treatment program have the positive effect in reducing detrimental anxiety in the surgery. Patient and the sex of the subject may be improvement variables to be incorporated in evaluating the effectiveness of this type of treatment program.

Lamarche et al. (1984) indicated that the appropriate time to offer the pre operative video assisted teaching program is on the eve of surgery. He stated that anxiety is the most important variable which affects the outcomes.

Nagurka R et al.(2010), conducted a study of Effectiveness of stroke education in the emergency department’s waiting room through video. In this, pilot randomized controlled trial, research team enrolled patients and visitors in the fast-track waiting area of the ED. The intervention group received an educational video program, one-on-one counseling, and stroke education materials, and completed at 13-question test after receiving the education. The control group completed the same test without receiving any education. Both groups completed the same test again for 1 and 3 months to assess stroke knowledge retention. There were a total of 329 participants: 151 in the control group and 178 in the intervention group. ED stroke education, which includes video program, one-on-one counseling, and written educational materials, is able to significantly increase knowledge on stroke. Modification and
reinforcement of education is needed to achieve better knowledge retention and favorable lifestyle modification.
CONCEPTUAL FRAME WORK

The conceptual frame work of the present study is based on the “Kings Goal Attainment Model” (1989).

According to Imogene King, nursing is defined as a process of action, reaction, interaction, where by nurses and patients share information about their perceptions. Through perception and communication they identify the problems, through which they set goals and face necessary actions.

Kings Goal Attainment theory is based on the concepts of personal, interpersonal and social systems including perception, judgment, action, reaction, interaction and transaction.

Perception

A person’s imports energy from the environment transforms processes and stores it. The study assumes that there is an interpersonal relationship between the nurse investigator and participants. The nurse investigator perceives that there is a need for the development of Video Assisted Teaching Module on THR measures based on the pre-test knowledge scores of participants. It improves a demand for Video Assisted Teaching Module on THR measures to the group.

Judgment

Analyze the areas of action to be carried out. In this study, the investigator judges that Video Assisted Teaching Module on exercises, diet, medications and lifestyle modifications may improve the knowledge of participants. On the other hand,
the participants will express a need for changing their lifestyle and judges themselves in the areas of life modifications.

**Action**

Individual exports the perceived energy as demonstrated by the observable behaviors by taking mental or physical action. The nurse investigator takes action for actual development on Video Assisted Teaching Module following judgment. The participants take action by making themselves ready for seeking information regarding their lifestyle changes.

**Reaction**

Reaction means developing action and acting on perceived choices for goal attainment. The action of nurse investigator and participant will lead to reaction. The nurse investigator makes the arrangements for disseminating the information regarding THR by conducting pre-test and in turn the participants make themselves prepared to study the Video Assisted Teaching Module and involve in post-test.

**Interaction**

Refers to the verbal and non-verbal behavior between an individual and the environment or among two individuals. It involves goal directed perception and communication. Action leads to interaction where one needs to execute for Video Assisted Teaching module on THR and the participants will be eager to acquire the knowledge by showing careful attention to the Video Assisted Teaching Module.
Transaction

Imogene King said that transaction is two individuals mutually identifying goals and have one means to achieve them. They reach an agreement about how to attain these goals and then set goals to achieve them. Transaction identifies the target areas of THR and an agreement has been made to access the acquisition of knowledge by involving in the post-test.

Feedback

The outcome may be satisfactory or unsatisfactory improvement in knowledge on THR after post-test. Satisfactory improvement indicates that the Video Assisted Teaching Module is effective. The unsatisfactory improvement in knowledge leads to rearrangement of prior situation by the nurse investigator where the total process is recycled.

Summary

This chapter has dealt with the background need for the study and statement of the problem, objectives, operational definitions, research hypothesis, assumptions and conceptual framework.
FIGURE 1: CONCEPTUAL FRAMEWORK BASED ON KING’S GOAL ATTAINMENT MODEL (1981)
CHAPTER III

METHODOLOGY.

Introduction.

Research methodology is a systematic way to solve the research problem. Polit (2004) stated that, methodology of research refers to the investigations of the ways of obtaining, organizing and analyzing data. Methodological studies address the development validation and evaluation of research tools or methods.

Research Approach

Quantitative research approach was used in this study.

Research Design

Pre – experimental study design. (One group pretest and post-test design) was adopted for this study.

<table>
<thead>
<tr>
<th>NR</th>
<th>Pre-test</th>
<th>Intervention</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>O₁</td>
<td>X</td>
<td>O₂</td>
<td></td>
</tr>
</tbody>
</table>

NR – Non Randomization.

O₁ - Pre-test.

X - Intervention.

O₂ – Post-test.
Setting

The study was conducted at C2 and C4 wards, MIOT Hospitals, Chennai. MIOT hospitals is a 500 bedded multi specialty hospital and has performed more than 35,000 joint replacements. Joint replacement is done in a high-tech nano technology. MIOT is a pioneer in pin hole surgery, key hole surgery and also pioneer in “Computer Navigated Total Hip Replacement” which helps in ligament balancing and placement of prosthesis with zero error. This surgery aims on vastly improving the longevity of the joint and state-of-the art equipments and renewed surgical skills to fit it with zero-error precision.

Population

The study population comprised of all patients undergoing THR.

Sample

In this study the samples are the patients undergoing THR in C2 and C4 wards, MIOT hospitals, Chennai.

Sampling technique

The sample was selected by using non-probability convenient sampling technique.

Sample size

The sample size selected for this study was 30.
Inclusion Criteria.

- Patients undergoing THR in MIOT hospital
- Patients who can speak and understand Tamil and English.
- Patients willing to participate.

Exclusion Criteria.

- Patients not willing to participate.
- Patients attending OPD.
- Patients who were critically ill.

Data Collection Tool.

The tool used for data collection was a structured questionnaire. It has four parts.

Part I of the tool, the demographic and baseline data. It consists of 13 items related to demographic and other baseline data of the patients undergoing THR.

Part II of the tool contains a knowledge questionnaire. It has 30 questions of which each right answer scores one mark and the wrong answer was not assigned any score. The maximum score is 30. The scoring is interpreted as:

Adequate Knowledge 75-100%,

Moderate Knowledge 51-74%,

Inadequate Knowledge < 50%.
Blue Print of the Tool

<table>
<thead>
<tr>
<th>Category</th>
<th>Knowledge Questions</th>
<th>No. of Items</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy &amp; Physiology</td>
<td>1,2</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Disease Condition</td>
<td>3</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Signs &amp; Symptoms</td>
<td>4</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Investigation</td>
<td>5</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Treatment</td>
<td>6,7</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Preparation for Surgery</td>
<td>8-12</td>
<td>5</td>
<td>17%</td>
</tr>
<tr>
<td>Pre-op Procedure</td>
<td>13</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Surgical Procedure</td>
<td>14</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Activity &amp; Exercise</td>
<td>15-29</td>
<td>15</td>
<td>50%</td>
</tr>
<tr>
<td>Home Modification</td>
<td>30</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

Part III of the tool contains the Attitude Questionnaire. It has 10 statements (5 positive & 5 negative statements) related to patient’s attitude on THR which are to be responded as strongly agree, agree, disagree, strongly disagree and don’t know.

Positive Question Score.  
Strongly Agree  - 4  
Agree  - 3

Negative Question Score.  
Strongly Agree  - 1  
Agree  - 2
Disagree - 2
Strongly Disagree - 1
Don’t Know - 0

Disagree - 3
Strongly Disagree - 4
Don’t Know - 0

The maximum possible score is 40 marks.

**Score on Attitude is interpreted as:**

- Good attitude  75-100%
- Fair attitude  51-74%
- Poor attitude  <50%

**Part IV** of the tool contains the Practice Observation Checklist for observing the practice of client undergoing total hip replacement. It consists of 10 questions regarding practices followed by the client after THR. Maximum score is 10.

**Scoring and interpretation**

Adequate Practice 75-100%

Moderate Practice 51-74%

Inadequate Practice <50%.

**Part V** Video Assisted Teaching Module on THR. It consists of Anatomy of Hip Joint, surgical procedure of THR, signs and symptoms of hip joint infection, preparing for surgery, diet, and exercise guidelines for THR, complications and general information.
Validity

The tool was developed through an extensive review of literature and sent to experts in the field of Nursing and Orthopedics for validation. Modifications were made according to the suggestions.

Reliability

The reliability of a tool was established by conducting a pilot study. The reliability of the knowledge Questionnaire tool was established by test–retest method and the score was $r = 0.94$ The Attitude Questionnaire tool reliability was established by split half method and the score was $r = 0.091$, the Practice observation checklist reliability was established by inter rated method and the score was $r = 1$.

Pilot Study

The pilot study was conducted in C1 ward in MIOT hospitals after obtaining the permission from Chief of the Orthopedic Department and the consent from the patients undergoing THR. Three samples were taken & video teaching on THR was given. The post-test was done after 3 days. It proved that the tool is valid and reliable and the study is feasible.

Data Collection Procedure

A formal permission was obtained from the department of Hip replacement to conduct the main study. The data collection was carried out for a period of 6 weeks from 30.5.11 to 9.7.11. The study samples was selected by non-
probability convenient sampling technique, thirty in-patient those who were admitted for THR surgery were selected. After obtaining informed consent from the participants, the pre-test was given which consists of the structured questionnaire on the knowledge, attitude of total hip replacement. After which a Video Assisted Teaching Module was given for 40 minutes and then practice of exercise was observed by using a likert checklist, by the investigator from the day of surgery to the 7th post operative day. The post-test was given on the day of discharge (7th day of surgery), which consists of the knowledge and the attitude of the patient on total hip replacement. The Data collection was done as per the following schedule:-

<table>
<thead>
<tr>
<th>No of Samples per day</th>
<th>Pre-test Date.</th>
<th>Post-test Date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>2.</td>
<td>20.6.2011.</td>
<td>27.6.2011.</td>
</tr>
<tr>
<td>1.</td>
<td>27.6.2011.</td>
<td>4.7.2011.</td>
</tr>
<tr>
<td>1.</td>
<td>28.6.2011.</td>
<td>5.7.2011.</td>
</tr>
</tbody>
</table>

**Human Rights Protection.**

The pilot and main study was conducted only after the research approval by the college of nursing and the Institutional Ethical Committee. Permission was obtained from all the participants who are taking part in the study. Consent was obtained from all the patients who participated in the study.
CHAPTER IV
DATA ANALYSIS AND INTERPRETATION.

This chapter deals with the analysis and interpretation which includes both descriptive and inferential statistics. Analysis is defined as the method of organizing data in such a way that the research questions can be answered. Interpretation is the process of making a sense of the result and of examining the simplification of the finding within a broader context


The findings based on the descriptive and inferential statistical analysis are presented under the following headings.

**Section I**: Description of Demographic Variables in frequency and percentage.

**Section II**: Distribution of existing Knowledge and Attitude of patient.

**Section III**: Distribution of Knowledge and Attitude score in the post-test.

**Section IV**: Distribution of Effective Knowledge and Attitude score on Total Hip Replacement.

**Section V**: Distribution of existing level of practice of patients after Total Hip Replacement.

**Section VI**: Correlation between the Knowledge, Attitude and Practice of patient.

**Section VII**: Association between selected Demographic Variables with post-test Knowledge, Attitude and Practice of patient.
Section I

This section deals with the description of demographic variables in frequency and percentage.

Table 1: Distribution of Demographic variables among Patients Undergoing Total Hip Replacement.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Demographic Variables</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Age in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) &lt;50 yrs</td>
<td>16</td>
<td>53.4</td>
</tr>
<tr>
<td></td>
<td>b) 51 – 65 yrs</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>c) 61 – 70 yrs</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>d) &gt; 71 yrs</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>2.</td>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Male</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>b) Female</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td>3.</td>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Hindu</td>
<td>21</td>
<td>70.0</td>
</tr>
<tr>
<td></td>
<td>b) Christian</td>
<td>6</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>c) Muslim</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>d) Others</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>4.</td>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Illiterate</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>b) Primary</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>c) High school</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>d) Higher Secondary</td>
<td>6</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>e) Diploma</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>f) Graduate</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>g) Post graduate</td>
<td>6</td>
<td>20.0</td>
</tr>
<tr>
<td>5.</td>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Single</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>b) Married</td>
<td>25</td>
<td>83.3</td>
</tr>
<tr>
<td></td>
<td>c) Divorced</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>d) Widow/Widower</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>6.</td>
<td>Family Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Rs. 1,000 – 5,000</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>b) Rs. 5,001 – 10,000</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>c) Rs. 10,001 – 20,000</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>d) &gt; Rs. 20,000</td>
<td>19</td>
<td>63.3</td>
</tr>
<tr>
<td>7.</td>
<td>Nationality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>Indian</td>
<td>27</td>
<td>90.0</td>
</tr>
<tr>
<td>b)</td>
<td>Foreigner</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>c)</td>
<td>Non Residential Indian</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.</th>
<th>Duration of Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Less than one year</td>
</tr>
<tr>
<td>b)</td>
<td>More than one year</td>
</tr>
<tr>
<td>c)</td>
<td>Don’t know</td>
</tr>
<tr>
<td>d)</td>
<td>Very recently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9.</th>
<th>Family History of Degenerative Hip Disorder (DHD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Yes</td>
</tr>
<tr>
<td>b)</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.</th>
<th>Previous Information about THR</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Friends &amp; relatives</td>
</tr>
<tr>
<td>b)</td>
<td>Health professionals</td>
</tr>
<tr>
<td>c)</td>
<td>Teachers</td>
</tr>
<tr>
<td>d)</td>
<td>Mass media</td>
</tr>
<tr>
<td>e)</td>
<td>Others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11.</th>
<th>How Regular in Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Very regular</td>
</tr>
<tr>
<td>b)</td>
<td>Irregular</td>
</tr>
<tr>
<td>c)</td>
<td>Very irregular</td>
</tr>
<tr>
<td>d)</td>
<td>Not on medication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12.</th>
<th>Practicing Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Yes</td>
</tr>
<tr>
<td>b)</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.</th>
<th>Indication for THR</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Hip fracture</td>
</tr>
<tr>
<td>b)</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>c)</td>
<td>Avascular necrosis</td>
</tr>
<tr>
<td>d)</td>
<td>Ankylosing spondylitis</td>
</tr>
<tr>
<td>e)</td>
<td>Trauma to the hip</td>
</tr>
<tr>
<td>f)</td>
<td>Others</td>
</tr>
</tbody>
</table>
Table 1: reveals that more number of the participants were in the age group of <50 years that is 16(53.4%), majority were male participants that is 20(66.7%), and (33.3%) were graduates. 21(70%) have no family history of Degenerative Hip Disorder, 14(46.7%) had Avascular Necrosis, only 6(20%) of the participants had previous information from health professionals regarding Total Hip Replacement. This shows that majority of the participants need education about Total Hip Replacement.
Figure 2 shows the educational status of the patients undergoing THR. In that 4(13.3%) of the patients have completed High school & Diploma and 6(20%) of the patients have completed their Higher secondary and Post Graduation.
This section deals with the distribution of existing Knowledge and Attitude of patients.

**Table 2: Mean and standard deviation of knowledge score on Total Hip Replacement in the Pre-test.**

<table>
<thead>
<tr>
<th>S.No</th>
<th>Knowledge Aspects</th>
<th>Descriptive Statistics</th>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>1.</td>
<td>Anatomy &amp; Physiology</td>
<td>51.67</td>
<td>42.51</td>
</tr>
<tr>
<td>2</td>
<td>Disease Condition</td>
<td>56.67</td>
<td>50.40</td>
</tr>
<tr>
<td>3</td>
<td>Signs &amp; Symptoms</td>
<td>30.00</td>
<td>46.61</td>
</tr>
<tr>
<td>4</td>
<td>Investigation</td>
<td>63.33</td>
<td>49.01</td>
</tr>
<tr>
<td>5</td>
<td>Treatment</td>
<td>63.33</td>
<td>31.98</td>
</tr>
<tr>
<td>6</td>
<td>Preparation for Surgery</td>
<td>48.00</td>
<td>17.10</td>
</tr>
<tr>
<td>7</td>
<td>Pre op Procedure</td>
<td>46.67</td>
<td>50.74</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Procedure</td>
<td>70.00</td>
<td>46.61</td>
</tr>
<tr>
<td>9</td>
<td>Activity &amp; Exercise</td>
<td>49.78</td>
<td>13.53</td>
</tr>
<tr>
<td>10</td>
<td>Home Modification</td>
<td>66.67</td>
<td>47.95</td>
</tr>
<tr>
<td></td>
<td>Overall knowledge.</td>
<td>51.67</td>
<td>8.61</td>
</tr>
</tbody>
</table>

Table 2: shows that all the participants have knowledge about Preparation for Surgery 20%, Activity & Exercise 26.7%. The overall mean knowledge was 51.67 and SD was 8.61. This shows that the participants need education about preparation for surgery, activity & exercise after Total Hip Replacement.
### Table 3: Distribution of Level of Knowledge on THR in pre test.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Knowledge Aspects</th>
<th>Inadequate Knowledge</th>
<th>Moderate Knowledge</th>
<th>Adequate Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>Anatomy &amp; Physiology</td>
<td>10</td>
<td>33.3</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Disease condition</td>
<td>13</td>
<td>43.3</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Signs &amp; symptoms</td>
<td>21</td>
<td>70.0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Investigation</td>
<td>11</td>
<td>36.7</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Treatment</td>
<td>3</td>
<td>10.0</td>
<td>16</td>
</tr>
<tr>
<td>6</td>
<td>Preparation for Surgery</td>
<td>15</td>
<td>50.0</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>Pre op Procedure</td>
<td>16</td>
<td>53.3</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Procedure</td>
<td>9</td>
<td>30.0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>Activity &amp; Exercise</td>
<td>17</td>
<td>56.7</td>
<td>13</td>
</tr>
<tr>
<td>10</td>
<td>Home Modification</td>
<td>10</td>
<td>33.3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Overall knowledge</td>
<td>10</td>
<td>33.3</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 3: show that 21(70%) of the patients have inadequate knowledge about signs and symptoms and 17(56.7%) of the patients have inadequate knowledge about Activity & Exercise. 16(53.3%) of the patients have moderate knowledge about treatment. In overall knowledge 10(33.3%) have inadequate knowledge and 20(66.7%) have moderate knowledge.
Table 4: Mean & Standard Deviation of Attitude score on Total Hip Replacement in Pre-test.

<table>
<thead>
<tr>
<th>Attitude Score</th>
<th>Descriptive Statistics</th>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D</td>
</tr>
<tr>
<td>Pre-Test</td>
<td>63.20</td>
<td>8.53</td>
</tr>
</tbody>
</table>

Table 4: shows that the high attitude mean score in the pre-test was 63.20 with the standard deviation of 8.53.
Figure 3 shows that majority of the participants were having moderate attitude 26(87%) in the pre-test. This shows that majority of the participants need education on THR.
SECTION III.

This section deals with the distribution of knowledge and attitude score in the post-test.

Table 5: Mean and Standard Deviation of Post-test Knowledge Score on Total Hip Replacement.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Knowledge Aspects</th>
<th>Descriptive Statistics</th>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>1</td>
<td>Anatomy &amp; Physiology</td>
<td>95.00</td>
<td>15.25</td>
</tr>
<tr>
<td>2</td>
<td>Disease Condition</td>
<td>86.67</td>
<td>34.57</td>
</tr>
<tr>
<td>3</td>
<td>Signs &amp; Symptoms</td>
<td>83.33</td>
<td>37.90</td>
</tr>
<tr>
<td>4</td>
<td>Investigation</td>
<td>83.33</td>
<td>37.90</td>
</tr>
<tr>
<td>5</td>
<td>Treatment</td>
<td>90.00</td>
<td>24.21</td>
</tr>
<tr>
<td>6</td>
<td>Preparation for Surgery</td>
<td>86.67</td>
<td>13.22</td>
</tr>
<tr>
<td>7</td>
<td>Pre op Procedure</td>
<td>86.67</td>
<td>34.57</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Procedure</td>
<td>86.67</td>
<td>34.57</td>
</tr>
<tr>
<td>9</td>
<td>Activity &amp; Exercise</td>
<td>86.67</td>
<td>9.74</td>
</tr>
<tr>
<td>10</td>
<td>Home Modification</td>
<td>100.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Overall knowledge: 87.67  6.84    73.3  96.7

Table 5: shows that the high knowledge mean score in post-test was found in Home modification Mean = 100 with a standard deviation of 0.00.
Table 6: Distribution of Level of Knowledge on Total Hip Replacement in post-test.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Knowledge Aspects</th>
<th>Inadequate Knowledge</th>
<th>Moderate Knowledge</th>
<th>Adequate Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1</td>
<td>Anatomy &amp; Physiology</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Disease Condition</td>
<td>4</td>
<td>13.3</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Signs &amp; Symptoms</td>
<td>5</td>
<td>16.7</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Investigation</td>
<td>5</td>
<td>16.7</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Treatment</td>
<td>1</td>
<td>3.3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Preparation for Surgery</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Pre op Procedure</td>
<td>4</td>
<td>13.3</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Procedure</td>
<td>4</td>
<td>13.3</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>Activity &amp; Exercise</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>Home Modification</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
</tbody>
</table>

| Overall Knowledge          | 0    | 0.0  | 1    | 3.3  | 29   | 96.7 |

Table 6: shows that 30(100%) of the patients have adequate knowledge about Home Modification and 27(90%) of the patients have adequate knowledge about anatomy & Physiology and Preparation for surgery. The overall knowledge of the patients in post-test was 1(3.3%) of patients have Moderate knowledge and 29(96.7%) patients have adequate knowledge in post-test.
Table 7: Mean & Standard Deviation of Attitude Score on Total Hip Replacement in Post-test.

<table>
<thead>
<tr>
<th>Attitude Score</th>
<th>Descriptive Statistics</th>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D</td>
</tr>
<tr>
<td>Post-Test</td>
<td>78.27</td>
<td>2.50</td>
</tr>
</tbody>
</table>

Table 7: shows that the high attitude mean score in post-test was 78.27 with a Standard Deviation of 2.50.
Figure 4: Percentage Distribution of Level of Attitude on Total Hip Replacement in the Post-Test.

Figure 4 show that the majority of the participants 28 (93.3%) were having high attitude in the post test.
Figure 5: Level of Existing Practice among the Participants who Underwent Total Hip Replacement.

Figure 5: shows that whole participants 30(100%) were having good practice after THR. This shows that the visual education of exercise enhanced the practice of patients after THR.
SECTION IV

This section deals with the distribution of effective knowledge and attitude score on Total Hip Replacement.

Table 8: Effectiveness of Video Assisted Teaching Module on Knowledge Score on THR.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Knowledge Aspects</th>
<th>Improvement Knowledge (n=30)</th>
<th>Paired t test and P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>1</td>
<td>Anatomy &amp; Physiology</td>
<td>43.33</td>
<td>46.85</td>
</tr>
<tr>
<td>2</td>
<td>Disease Condition</td>
<td>30.00</td>
<td>46.61</td>
</tr>
<tr>
<td>3</td>
<td>Signs &amp; Symptoms</td>
<td>53.33</td>
<td>50.74</td>
</tr>
<tr>
<td>4</td>
<td>Investigation</td>
<td>20.00</td>
<td>61.02</td>
</tr>
<tr>
<td>5</td>
<td>Treatment</td>
<td>26.67</td>
<td>31.44</td>
</tr>
<tr>
<td>6</td>
<td>Preparation for Surgery</td>
<td>38.67</td>
<td>18.89</td>
</tr>
<tr>
<td>7</td>
<td>Pre op Procedure</td>
<td>40.00</td>
<td>67.47</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Procedure</td>
<td>16.67</td>
<td>53.07</td>
</tr>
<tr>
<td>9</td>
<td>Activity &amp; Exercise</td>
<td>36.89</td>
<td>13.42</td>
</tr>
<tr>
<td>10</td>
<td>Home Modification</td>
<td>33.33</td>
<td>47.95</td>
</tr>
</tbody>
</table>

Overall Knowledge | 36.00 | 10.11 | 19.503 | 0.000 ***
Note: * - P<0.05, ** - P<0.01, *** - P<0.001 Level of significant

Table 8: interprets that the overall improvement of knowledge and mean score of 36.00 with a Standard Deviation of 10.11. The t value= 19.503 which is highly significant at p<0.001. Hence the research Hypothesis H₁ is accepted.
Table 9: Effectiveness of Video Assisted Teaching Module on Attitude score on Total Hip Replacement

<table>
<thead>
<tr>
<th>Paired t–test</th>
<th>Improvement Attitude (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Mean</td>
<td>15.07</td>
</tr>
<tr>
<td>Effective Standard Deviation</td>
<td>8.72</td>
</tr>
<tr>
<td>Paired t–test &amp; P value</td>
<td>t = 9.462</td>
</tr>
</tbody>
</table>

Note: *** P<0.001 Level of significant

Table 9: shows that the effective mean attitude score was 15.07 with a standard deviation of 8.72 and the paired t value of 9.462, which is significant at p<0.001. Hence the research Hypothesis H₁ is accepted.
### SECTION VI

**Table 10: Correlation between the Knowledge, Attitude and Practice in Post-test**

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Knowledge</th>
<th>Attitude</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r – value and P value</td>
<td>r – value and P value</td>
<td>r – value and P value</td>
</tr>
<tr>
<td>Knowledge</td>
<td>r = 1.00</td>
<td>r = 0.198, P = 0.293 (N.S)</td>
<td>r = 0.398, P = 0.029 *</td>
</tr>
<tr>
<td>Attitude</td>
<td>r = 1.00</td>
<td>r = 0.368, P = 0.046 *</td>
<td>r = 1.00</td>
</tr>
</tbody>
</table>

*Note: * - P<0.05, Level of significant, N.S. – Not Significant

Table 10 reveals that the correlation of knowledge, attitude and practice in the post-test is significant at p<0.05.
This section deals with the association between selected demographic variables with post-test knowledge, attitude and practice of patient.

### Table 11: Association between Post-test Knowledge on THR and Demographic Variables among Patients Undergoing THR.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Demographic Variables</th>
<th>Knowledge in Post-test</th>
<th>ANOVA test &amp; P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>1</td>
<td>Age in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) &lt;50 yrs</td>
<td>16</td>
<td>88.12</td>
<td>6.98</td>
</tr>
<tr>
<td>b) 51 – 65 yrs</td>
<td>10</td>
<td>89.67</td>
<td>6.37</td>
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Table 11: shows that the ANOVA test on demographic variables has no significant association with post-test knowledge of patients who have undergone THR.
### Table 12: Associations between Post-test Attitude on THR and Demographic Variables among Patients Undergoing THR

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Note: * - P<0.05, Level of significant, N.S. – Not Significant

Table 12: shows that the ANOVA test on demographic variables has no significant association with post-test Attitude of patients undergoing THR and practicing exercise.
Table 13: Associations between Post-test Practice on THR and Demographic Variables among Patients Undergoing THR.

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Note: ** - P<0.01, Level of significant, N.S. – Not Significant

Table 13 shows that the ANOVA test value of demographic variables has no significant association with post test practice of patients undergoing THR except the previous information about THR.
CHAPTER V

DISCUSSION

The present study aimed at teaching patient undergoing THR in order to make them aware of THR, its management and home management. It helps them to move better at work, play and rest. This Video Teaching Module on Total Hip replacement improves the knowledge of the Patient and prevents further complications. This is one group pre and post-test experimental study intended to assess the effectiveness of Video Assisted Teaching module on knowledge, attitude and practice among patients undergoing THR, in MIOT hospitals, Chennai. Demographic data reveals that more number of the participants were in the age group of <50 years, that is 16(53.4%), majority were male participants, that is 20(66.7%), 10(33.3%) were graduates. 21(70%) have no family history of Degenerative Hip Disorder, 14(46.7%) had Avascular Necrosis, only 6(20%) of the participants had previous information from health professionals regarding Total Hip Replacement. This shows that majority of the participants need education about Total Hip Replacement.

The first objective of the study was to assess the existing knowledge and attitude of the patients who is undergoing for THR.

The questionnaire method was used to assess the knowledge, attitude and practice. As per table figure1, most of the patient 20(66.7%) had moderate knowledge and 10(33.3%) had inadequate knowledge. Table 2 shows that the overall mean knowledge score was 51.67 with standard deviation 8.61. Attitude were assessed through likert scale. Figure 3 shows that in pre-test the patients
3(10.0%) had poor attitude and 26 (86.7%) had moderate attitude. The mean pre-test attitude score was 63.20 with standard deviation of 8.53 as given in table 5. So the investigator felt that the most of the patients had inadequate knowledge and moderate attitude. So they need teaching.

The second objective was to determine the effectiveness of Video Assisted Teaching module on knowledge, attitude and practice on THR among patients undergoing THR.

Measures were provided to improve the knowledge, attitude and practice through video teaching regarding Total hip replacement. As per table 8 the obtained t value in knowledge was 19.503 at (P= 0.000), in attitude the t value was 9.462 at (P= 0.000) as given in table 9. Table 4 shows that the mean post-test knowledge score was 100 and post-test mean attitude score was 78.27. As given in table 6 the post-test mean practice score was 87.67 and the mean score of post-test knowledge, attitude and practice was higher after video teaching. So the investigator found that there is an improvement in knowledge, attitude and practice of the patients on THR after video teaching programme. The obtained t value for post-test knowledge and attitude was significant at P<0.001 level. So the research hypothesis was accepted.

Similarly many study shows that the video teaching is the method of teaching.

Wong (2003), stated that culturally sensitive educational video material using familiar metaphors can be shown to have a statistically significant effect on patient’s knowledge of medication taking concepts.
Nagurka R et al. (2010), conducted a study of Effectiveness of stroke education in the emergency department’s waiting room through video. In this, pilot randomized controlled trial, research team enrolled patients and visitors in the fast-track waiting area of the ED. The intervention group received an educational video program, one-on-one counseling, and stroke education materials, and completed at 13-question test after receiving the education. The control group completed the same test without receiving any education. Both groups completed the same test again for 1 and 3 months to assess stroke knowledge retention. There were a total of 329 participants: 151 in the control group and 178 in the intervention group. ED stroke education, which includes video program, one-on-one counseling, and written educational materials, is able to significantly increase knowledge on stroke. Modification and reinforcement of education is needed to achieve better knowledge retention and favorable lifestyle modification.

Bowering et al. (2000), conducted a study to attempt to video tape preparation of patients before hip replacement surgery with the aim of reducing stress and anxiety which showed that the use of video tape decreased anxiety and stress measured in terms video of urinary cortical excretion and intra operative systemic blood pressure in patients undergoing hip replacement surgery. This prepared them to cope better with the post operative pain.

The conceptual framework adapted for this study was King’s Goal Attainment theory. It involves the baseline data of the subjects, Intervention (Video Assisted Teaching Module on Total Hip Replacement) and the level of
knowledge, attitude and practice. It was modified and adopted model for this study. It provides a comprehensive, systemic and continuously ongoing framework for evaluation of an innovative intervention.

So the investigator felt that the formal educational teaching, plays a major role to improve the knowledge, attitude and practice of the patients undergoing THR and that the video teaching is more effective.

**The third objective was to correlate the post-test knowledge, attitude and practice of patients undergoing THR.**

The correlation score between the posttest knowledge and attitude of table 11 shows that the r value was 1.00. This reveals that improvement in knowledge significantly influences the attitude of the patient undergoing THR. So this improvement shows that the obtained r value was significant at P<0.05. It shows high correlation of knowledge, attitude and practice. Hence the research hypothesis is accepted.

A similar study conducted by Prof. Latha Venkatasan, Apollo College of Nursing in Chennai, (2008) revealed that the video program on road safety was effective in bringing out the positive changes in the knowledge and attitude of school children who took part in the programme. In the pre-test there was a low moderate positive correlation (r = 0.032) between knowledge and attitude whereas in the post-test moderately positive correlation (r = 0.42) between the knowledge and the attitude was seen.
The fourth objective was to associate between selected demographic variable with the post-test knowledge and attitude score.

Table 13 shows that the demographic variables, age of the patient, gender, religion, education, marital status, family income, nationality, duration of illness, family history of degenerative hip disorder, previous information about THR, how regular in medication, practicing exercise, indication for THR were not associated with post-test knowledge. But as per table 11 the post-test attitude of the patient has an association only with gender, previous information about THR and practicing exercise. The other variables have no association. Therefore, it reveals that there is no significant difference between post-test knowledge and attitude score at P < 0.05 level, so the hypothesis was not accepted.

Robertson et al. (1991), suggested that video tapped behavioral treatment programme have the positive behavioral treatment programme have the positive effect in reducing detrimental anxiety in the surgery. Patient and the sex of the subject may be an improvement variable to be incorporated in evaluating the effectiveness of this type of treatment programme. So the investigator found that the video teaching is more effective in improving the knowledge and attitude of the care givers.

Ms.G.R.Neelimarani (2009) study to assess the knowledge gain with Video Assisted Teaching on kangaroo mother care among B.Sc Nursing III year students at NIMS College of Nursing. Total score and item wise analysis on kangaroo mother care among B.Sc nursing III year students are found to be improved (35.22) with pre test and post test scores, hence, null hypothesis is
rejected and research hypothesis accepted. Effectiveness of video assisted teaching on kangaroo mother care shows, an improvement of knowledge scores with pre test and post test by using paired ‘t’ test. The ‘t’ value is 9.6429 at 29 degrees of freedom, it shows highly positive. Hence research hypothesis (H1) is accepted and null hypothesis rejected. (H0).
CHAPTER VI

SUMMARY, CONCLUSION, LIMITATIONS, IMPLICATIONS AND RECOMMENDATION

Summary

The present study was designed to assess the effectiveness of Video Assisted Teaching module on knowledge, attitude and practice among patient undergoing Total Hip Replacement at MIOT hospitals in Chennai.

The conceptual framework adapted for this study was Kings Goal attainment theory and the methodology used was quantitative approach to assess the effectiveness of video assisted teaching module and the research design used for the study was pre experimental study design and the setting was in MIOT hospitals C2 and C4 wards. The study population comprised of patients who were undergoing THR. The sampling technique used was non probability convenient sampling technique and questionnaire was given totally to 30 patients. The study tested and proved the hypothesis, there was gain in knowledge, attitude and practice regarding THR and management. As a nursing intervention video assisted teaching module on THR was selected as independent variables with the knowledge, attitude and practice gained in post-test was dependent variables.

Major finding of the study are the distribution of demographic value were according to the patients undergoing Total Hip replacement (THR) 16(53.4%) were < 50 years, 10(33.3%) were between 51-65 years. With regards to gender
20(66.7%) were male and 10(33.3%) were female. With regards to religion 21(70.0%) were Hindu, 6(20%) were Christian. Out of 30 patient’s educational status 6(20%) were completed higher secondary school and post graduates, 10(33.3%) were graduates. With regards to marital status 4(13.35) were single, 25(83.3%) were married. With regards to family income per month 8(26.7%) earn between Rs.10,001-20,000, 19(63.3%) earn more than Rs, 20000. In regards to nationality most of them 27(90%) were Indians. According to the duration of illness 12(40%) are suffered more than one year. With regards of family history of Degenerative Hip Disorder 9(30%) had disease and 21(70%) have no family history of Degenerative Hip Disorder. With regards 12(40%) of patient got previous information about THR through friends and relatives and also through mass media and 6(20%) got information through Health Professionals. Out of 30 patients, 16(53.3%) were on very regular medication, 4(13.3%) were irregular and very irregular, and 6(20%) were not on medication. Regarding exercise 13 (43.3%) patients were practicing and 17(56.7%) were not practicing exercises. With regards of indication for THR, 14(46.7%) had Avascular necrosis, 9(30%) had Osteoarthritis and 6(20%) patients had hip fracture.

In pre and post-test mean score of knowledge of this study were 70 and 100 respectively, the mean attitude of the study were 63.20 and 78.27 and the post-test mean practice of this study were 87.67 which shows improvement in knowledge and attitude and practice. The obtained t value of knowledge of the study was 19.50 and the mean attitude score t value of 9.462, which was highly significant at P<0.001 level, which indicated the effectiveness of video programme on THR. The co-relation between post-test knowledge, attitude and
practice obtained a value of r=1.00. This is significant at P< 0.05, which shows a high correlation. There was no significant association of demographic variables with post-test knowledge at P < 0.05 level, so the hypothesis is rejected. There was no association of demographic variables with post-test attitude except gender, previous information about THR and practicing exercise.

**Conclusion**

The overall pre-test and post-test mean knowledge score was 51.67 and 87.67, the mean attitude score was 63.20 and 78.27 respectively and post-test mean score was 87.67. The t value shows that effectiveness of knowledge, attitude and practice on video teaching programme was highly significant at P< 0.001. The educative measure shows that significant improvement in knowledge, attitude and practice on THR among patients undergoing THR.

**Limitations**

- The study was limited to patients undergoing Total Hip Replacement at MIOT hospitals. So the findings cannot be generalized.

- The study was limited to patients in C2 and C4 ward at MIOT hospitals. So the finding cannot be generalized.

- The study was limited to patients in In-patient department.

- The data collection period was limited to six weeks.

- The Study was restricted only to the patients undergoing THR.
• Convenient sampling technique was used due to inadequacy of sample.

**Nursing implications**

Numerous implications can be drawn from the present study for practice which promotes and creates new dimension to nursing profession.

**Nursing education**

• Nursing education aims for the future nurses who play a major role in providing care to the patient, which includes teaching also. So the nursing students should have adequate knowledge to communicate with the patients undergoing THR.

• This study also helps the students to use an effective teaching aid for the patient to improve the knowledge, attitude and practice regarding THR.

**Nursing practice**

• These study findings can be used to define THR, its management and home modification. So the intervention can be planned and the care given.

• The nurses can use video assisted teaching method for better understanding of the disease condition and home care management.

• The nurses can prepare the real picture of the illness and prognosis of the patient after management through video which will be the effective in teaching and the nurse can use this video whenever the patient is admitted with the same disease.
• This study helps the nurse to give an effective teaching with appropriate pictures for better understanding of the THR and its management through video and also it save time and energy because it can be reproduced whenever required.

**Nursing administration**

• Nursing administrators could develop standards, protocol and various audio visual aids for teaching the patients undergoing THR.

• Nursing administrators can plan and conduct the in-service education for the staff regarding communication through video assisted teaching method.

• The nurse administrators must initiate a plan to validate the video assisted teaching method prepared by any researchers and can use this when the patient is admitted for THR.

**Nursing research**

• For improving the knowledge, attitude and practice of the patient, various teaching method can be used through research. Also the effectiveness of the research study can be made by further implication of study.

• The nurses can utilize evidence based practice to improve the knowledge, attitude and practice of the patient undergoing THR.

• It helps to educate the patients effectively and recommends policy changes and promotes the nursing status and image. So the nurses are
encouraged to do research on various methods of teaching to improve the knowledge, attitude and practice of the patients undergoing THR.

**Recommendation**

- A true experimental study can be conducted by using the control group.
- The study can be conducted for a large group to validate the findings for generalization.
- The study can be conducted to know the practice of management by the patients undergoing THR.
- A comparative study can be conducted in different hospitals to identify the level of understanding of the patients with different age groups.
- A similar study can be done by using the various methods of teaching aid like programmed instruction, Self Instruction Module, IEC and Interactive Video and Audio Methods.
- A similar study can be done to compare with other orthopedic problems or any associated problems.
BIBLIOGRAPHY.


APPENDIX-A

LETTER SEEKING PERMISSION TO CONDUCT THE STUDY

From
Selvi K,
II year M.Sc(N)
MIOT College of Nursing
Chennai -116.

Forwarded through
Prof. Mrs. S Ani Grace Kalaimathi M.sc (N) PGDNA, DQA, Ph.D
Principal
MIOT College of Nursing
Chennai -116

To
Prof. Dr. P.V.A. Mohandas
M.S.ORTHO, M.CH.ORTHO (Liverpool, England), D.Ortho.D.Sc(Hon)
Chief Surgeon
Department of Orthopaedic Surgery.
MIOT Hospitals,
Chennai -116.

Subject: Requesting permission to conduct research in MIOT Hospitals.

Dear Sir,

As part of M.sc.(N) requirement under the fulfillment of Tamil Nadu Dr. M.G.R. Medical University, Guindy, Chennai, I am conducting a research on "Effectiveness of video assisted teaching module on knowledge attitude and practice among patients undergoing Total Hip Replacement in MIOT Hospitals, Chennai." I kindly request you to permit me to do my study in MIOT Hospitals C2 and C4 wards.

Thanking You,

Yours sincerely,

(SELVI. K)
APPENDIX- II

RESEARCH INFORMED CONSENT

I am SELVI. K. M. Sc Nursing II year student at MIOT College of Nursing, Chennai.

As a part of my study research on **Pre Experimental Study to Assess the Effectiveness of Video Assisted Teaching Module on Knowledge, Attitude and Practice among Patients Undergoing Total Hip Replacement in MIOT hospitals, Chennai** is selected to be conducted. The finding of the study will be helpful in utilizing the intervention for the patients undergoing Total Hip Replacement.

I hereby seek your consent and cooperation to participate in the study. Please be frank and honest in your response. The information collected will be kept confidentially and anonymity.

Signature of the investigator.

I ___________________ hereby consent to participate and undergo the study

Date:

Place:  

Signature of the participant.
APPENDIX – C

SECTION –I

Tool for assessing Knowledge, Attitude and Practice on Total Hip Replacement.

INSTRUCTION
Please read every question carefully and put tick mark [✓] and indicate the response that you choose in the space provided.

Demographic Variables
1. Age (in Years)
   a) <50 years.
   b) 51-65 years.
   c) 61-70 years.
   d) > 71 years. ( )

2. Sex
   a) Male.
   b) Female. ( )

3. Religion
   a) Hindu.
   b) Christian.
   c) Muslim.
   d) Others. ( )

4. Education
   a) Illiterate
   b) Primary
   c) High school (6-10)
   d) Higher secondary
   e) Diploma
   f) Graduate
   g) Post graduate ( )

5. Marital status.
   a) Single.
   b) Married.
   c) Divorced.
   d) Widow/ Widower. ( )

6. Family income per month
   a) Rs. 1,000-5,000
   b) Rs.5,001-10,000
   c) Rs. 10,001-20,000.
d) Rs > 20,000.

7. **Nationality**
   a) Indian
   b) Foreigner
   c) Non resident of India.

8. **Duration of awareness about the illness**
   a) Less than one year
   b) More than one year
   c) Don’t know.
   d) Very recently.

9. **Family history of Degenerative Hip disorders?**
   a) Yes
   b) No

10. **Previous information about Total Hip Replacement, Yes/No** [If yes, source of information]
    a) Friends and relatives
    b) Health professionals
    c) Teachers
    d) Mass media
    e) Others

11. **How regular are you in medication for your Hip problem?**
    a) Very Regular.
    b) Irregular.
    c) Very Irregular.
    d) Not on medication.

12. **Are you practicing any exercise regularly?**
    a) Yes.
    b) No.
    c) If yes, specify ----------------

13. **Indication for THR?**
    a) Hip fracture.
    b) Osteoarthritis.
    c) Avascular necrosis.
    d) Ankylosing spondylitis.
    e) Trauma to the hip.
    d) Any other. Specify ________.
PART - B
QUESTIONNAIRE TO ASSESS THE KNOWLEDGE ON TOTAL HIP REPLACEMENT.

Anatomy & Physiology.
(1) Which are the bones are attached to the pelvic bone?
   (a) Humerus
   (b) Tibia & Fibula.
   (c) Femur
   (d) Acetabulum & Femur.

(2) Hip joint is
   a) Fixed joint.
   b) Slightly movable joint.
   c) Freely movable joint.
   d) Ball and socket joint.

Disease Condition.
(3) What do you mean by degenerative joint disorder?
   (a) Wear and tear of joint cartilage.
   (b) Infection of the joint.
   (c) Calcium insufficient in the joint.
   (d) Widening of the joint.

Signs and Symptoms.
(4) Which one of the following is a common symptom of degenerative joint disorder?
   (a) Stiffness of the joints.
   (b) Weight gain
   (c) Fracture.
   (d) Vomiting and Nausea.

Investigation.
(5) Which is the confirmatory test for degenerative joint disorder?
   (a) Blood test.
   (b) ECHO.
   (c) Radiological studies.
   (d) Ultra sound.

Treatment.
(6) What is the surgery done to correct the degenerative Hip disorder?
   (a) Laparotomy.
   (b) Laparoscopy.
   (c) Total Hip Replacement.
   (d) Total Knee Replacement.

(7) What do you mean by Total Hip Replacement?
   (a) Repair of pelvic bone.
   (b) Correction of hip bone.
   (c) Replacing hip with an artificial joint.
   (d) Fixing of plate and screw.
Preparation for Surgery.

(8) Which one of this condition requires THR?
   (a) Patient with Avascular Necrosis.
   (b) Patient with Knee arthritis.
   (c) Patient with Knee pain.
   (d) Patient with lower abdominal pain.

(9) What is the need for THR?
   (a) To lengthen the height.
   (b) To reduce infection.
   (c) To improve quality of life overall.
   (d) Cosmetic surgery.

(10) What is the investigation to be done prior to surgery?
   (a) ECG (electrocardiogram)
   (b) Mantoux test.
   (c) Widal test.
   (d) Eye test.

(11) Which is the mandatory health check-up to be done before undergoing THR?
   (a) Eye check-up.
   (b) Dental check-up.
   (c) Neurological assessment.
   (d) Nutritional assessment.

(12) What type of drug should be avoided one week before the surgery?
   (a) Aspirin & Plavix.
   (b) Antibiotics.
   (c) Antiasthmatics
   (d) Antihypertensive.

Pre op Procedure.

(13) From when should the patient not eat or drink prior to surgery?
   (a) Do not eat or drink after midnight on the day before surgery..
   (b) Do not eat or drink before one day.
   (c) Do not eat or drink from the morning of surgery.
   (d) No need for fasting before surgery.

Surgical Procedure.

(14) Artificial Hip joint is made up of
   (a) Rubber.
   (b) Plastic.
   (c) Metal or cement.
   (d) Wood.

Activity and Exercise.

(15) Are you allowed to do exercise before surgery? If so how long?
   (a) Yes. 5 days before surgery.
   (b) Yes. 6-12 weeks before surgery.
   (c) Yes. 2 days before surgery.
(d) No.

(16) When can you perform Buttocks lifting exercise?
(a) After one month of surgery.
(b) After 6 hours of surgery.
(c) After 1 week of surgery.
(d) Before and after surgery.

(17) What type of activity can be done on the 1st post operative day?
(a) House hold activity.
(b) Walking in the Parallel Bar.
(c) Active ankle ROM exercises
(d) Climbing the staircase.

(18) What leg position is to be maintained after THR?
(a) Prone position.
(b) Semi Fowlers’ position.
(c) Lateral position.
(d) Hip in abduction position.

(19) When can you walk after THR?
(a) 1 week after THR.
(b) 3 days after THR.
(c) 1 hour of THR.
(d) 24 hours after THR.

(20) When can you climb the staircase?
(a) By 7 days after surgery.
(b) 6 months after surgery.
(c) 5th day of surgery.
(d) 12 months after surgery.

(21) When can patients bear full weight after THR?
(a) After 1 year.
(b) After 1 week.
(c) After 3 months.
(d) After 1 month.

(22) What is the dangerous position to move the hip after THR?
(a) Widening the legs.
(b) Outward rotation of the knees.
(c) High sitting.
(d) Flexion with inner rotation of the hip.

(23) How long should you use the abduction pillows?
(a) 4-6 weeks after surgery.
(b) 6-12 weeks after surgery.
(c) 12-18 weeks after surgery.
(d) 18-24 weeks after surgery.

(24) What special device is advised to achieve modified independence in ADL?
(a) Low toilet seats.
(b) Low cushion sofa.
(c) Elevated toilet seats.
(d) Low beds.

(25) How often you should change your position to prevent stiffness?
(a) 1 hour.
(b) 45 minutes.
(c) 15 minutes.
(d) 30 minutes.

(26) What is the method to get into the car?
(a) Operated leg first and non-operated leg next.
(b) Both the legs together.
(c) Non operated leg first and operated leg next.
(d) Should not travel in car.

(27) When can you return to your normal sexual activity?
  a) 5-6 days after surgery.
  b) 6-7 days after surgery.
  c) 10-14 days after surgery.
  d) One month after surgery.

(28) When will the sutures be removed?
  a) 5-6 days after surgery.
  b) 6-7 days after surgery.
  c) 10-14 days after surgery.
  d) One month after surgery.

(29) When should you come for review after discharge?
  a) One month after surgery.
  b) One week after surgery.
  C) Two weeks after surgery.
  d) One year after surgery.

Home Modification.

(30) What type of modification is to be done in the your house after discharge?
  a) Remove throw rugs.
  b) Place a rubber mat or non-skid adhesive on the floor.
  c) Place night lights and place in bathroom, bedroom and hallways.
  d) All of the above.

Correct answers: 1) d, 2) d, 3) a, 4) a, 5) c, 6) c, 7) c, 8) a, 9) c, 10) a, 11) b, 12) a, 14) c, 15) a, 16) d, 17) b, 18) d, 19) c, 20) c, 21) b, 22) d, 23) a, 24) c, 25) b, 26) c, 27) c, 28) c, 29) a, 30) d.
### SECTION III

**ATTITUDE QUESTIONNAIRE BASED ON LIKERT 5 POINT SCALE.**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When the patient is observed with pain and joint stiffness he should be taken to the orthopaedican.</td>
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<td>2. Patient with Ankylosis does not have any surgical treatment.</td>
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<td>3. THR is performed for the relief of pain caused by severe arthritis.</td>
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<td>4. THR is the removal of the damaged hip joint and replacing an artificial joint.</td>
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<tr>
<td>5. Patient who underwent THR should avoid calcium rich diet.</td>
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<tr>
<td>6. The most common complication of THR is dislocation of the artificial hip joint.</td>
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<td>7. The patient who came undergone THR should not to be protected from excessive activities</td>
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<tr>
<td>8. Follow up care is not necessary for the patient undergoing THR and to evaluate the prognosis.</td>
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<td>9. Patient should do active exercises regularly after discharge.</td>
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<tr>
<td>10. Patient who has undergone THR cannot have normal sexual activities.</td>
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</tbody>
</table>

**Positive questions:** 1, 3, 4, 6, 9. **Negative questions:** 2, 5, 7, 8, 10.
SECTION IV.

CHECK LIST TO ASSESS THE PRACTICE AFTER THR.

1. The patient is ambulated within 6 hours after surgery. Yes/No.

2. The patient wears stockings after surgery. Yes/No.

3. The patient raises the knee higher than the Hip. Yes/No.

4. The patient sits on low chairs, sofas and bed after surgery. Yes/No.

5. The patient is keeping both the legs in abducted position with pillows. Yes/No.

6. The patient is crossing both the legs after THR surgery. Yes/No.

7. The patient is taking calorie and iron rich diet after THR. Yes/No.

8. The patient is performing Parallel Bar walking exercise by his/her own. Yes/No.

9. The patient is practicing Pelvic Bridging exercise. Yes/No.

10. The patient bends the hip more than 90 degrees. Yes/No.
APPENDIX-D

பதிப்பு-I

இருப்பிட் அதையும் காண்பது அதிகரித்து பணியும், குறுக்கில் மேற்கு பரிசை நிற்கப்பட்ட சகாதாட்சம்.

குறிப்பிட்டம் குறிப்பிட்டதொடர்க்கும் குறிப்பிட்ட மதியதற்கு (v) அறிவுத்திறன் குறிப்பிட்டு.

குறிப்பிட்டு குறிப்பிட்டு:

1. மேலே.
   (i) < 50 மேலே.
   (ii) 51-65 மேலே.
   (iii) 61-70 மேலே.
   (iv) > 71 மேலே.

2. பரப்பலே.
   (i) குறும்ப.
   (ii) பத்தை.

3. புதுமே.
   (i) குறும்ப.
   (ii) குறும்ப.
   (iii) புதுமே.
   (iv) புதுமே.

4) குறும்பே.
   (i) முற்பாட்டிக்கொண்டு குறும்பே.
   (ii) முற்பாட்டிக்கொண்டு குறும்பே.
   (iii) பந்தை குறும்பே.
   (iv) பந்தை குறும்பே.

5) குறும்பே விளக்கம்
   (i) குறும்பே சேர்க்கும் விளக்கம்
   (ii) குறும்பே சேர்க்கும் விளக்கம்
   (iii) குறும்பே பந்தை விளக்கம்
   (iv) குறும்பே / பந்தை விளக்கம்

6) குறும்பே குறும்பே விளக்கம்
   (i) குறும்பே 1000-5000
   (ii) குறும்பே 5001-10,000
   (iii) குறும்பே 10,001 - 20,000
7) அங்கம்
   அ) சிறந்த போது
   அருகில் எளியது
   இ) சிறந்த போது
   எ) சிறந்த போது
8) சிக்கல் சமச்செய்யப் பாதிக்கும் பாதிக்கும் பாதிக்கும் பாதிக்கும்
    வருவதை கேளுங்கள்?
    அ) எதையும் நூற்றும் கேளுங்கள்
    இ) எதையும் நூற்றும் கேளுங்கள்
9) அம்சாக பணப்படுத்திகள் பணச்சாரணம் சின்ன வட்டமாக பரிசார்க்கிறீர்கள்
    எதைக்கள?
    ஆ) முதல்
    இ) முதல்
10) அம்சாக கட்டு கட்டு பணச்சாரணம் சின்ன வட்டமாக பரிசார்க்கிறீர்கள்
    எதைக்கள? ஆ)துதுதுகள். (ஆது எதைக்கள் எதைக்கள்)
    இ) பணச்சாரணம்
    இ) பணச்சாரணம்
11) இந்தக் குறிப்பிட்டு பணச்சாரணம் பரிசார்க்கிறீர்கள் எதைக்கள்?
    ஆ) எதையும் பணச்சாரணம்
    இ) சிறந்த பாதிக்கும் வேறுபட்டவை
    இ) எதையும் பணச்சாரணம்
    இ) எதையும் பணச்சாரணம்
12) அம்சாக கட்டு கட்டு முது முது பரிசார்க்கிறீர்கள்
    எதைக்கள?
    ஆ) முதல்
    இ) முதல்
    இ) முதல்
13) சின்ன வட்டமாக பணச்சாரணம் தீவுத்தல் என்று காரணமாக காரணமாக
    எதையும் சின்ன வட்டமாக
    அ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
    இ) சின்ன வட்டமாக
பதிப்பு - II

1) இடுப்பு எலும்புடன் வாதொடர்பு மருத்துவத்தில் செய்யப்பட்டுள்ள ஆய்வுகளின் மூலம் ஒரு பெரும் செவ்வைகள்

2) இடுப்பு எலும்பு வாதொடர்பு

3) இடுப்பு வழிபாட்டின் செயல்பாடு செய்யப்பட்டுள்ள ஆய்வுகள்

4) இடுப்பு வழிபாட்டின் வருவாய்ப்பு செய்யப்பட்டுள்ள ஆய்வுகள்

5) இடுப்பு வழிபாட்டின் வருவாய்ப்பு செய்யப்பட்டுள்ள ஆய்வுகள்

6) இடுப்பு வழிபாட்டின் வருவாய்ப்பு செய்யப்பட்டுள்ள ஆய்வுகள்

7) இடுப்பு வழிபாட்டின் வருவாய்ப்பு செய்யப்பட்டுள்ள ஆய்வுகள்

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8) இருது விஜயமாகச் செல்வது என்று அறியவும் விளக்கத்தகம் பொறுப்பில் வெளியே விளக்கத்தம் பொறுப்பில்?
   ஆ) இருது விஜய விளக்கத்தகம் விளக்கத்தகம் விளக்கத்தகம்
   இ) விஜயம் விளக்கத்தகம் விளக்கத்தகம்
   க) இந்து விளக்கத்தகம் விளக்கத்தகம்
   ம) இந்து விளக்கத்தகம் விளக்கத்தகம்

9) இருது விஜயம் அறிவும் விளக்கத்தகம் துளைப்பிட்டது?
   ஆ) காரணம் விளக்கத்தகம்
   இ) விளக்கத்தகம் விளக்கத்தகம்
   க) விளக்கத்தகம் விளக்கத்தகம்
   ம) விளக்கத்தகம் விளக்கத்தகம்

10) அறிவும் விளக்கத்தகம் பொறுப்பு விளக்கத்தகம் பொறுப்பில் வெளியே விளக்கத்தம்?
    ஆ) இந்து விளக்கத்தகம்
    இ) விளக்கத்தகம் விளக்கத்தகம்
    க) இந்து விளக்கத்தகம் விளக்கத்தகம்
    ம) இந்து விளக்கத்தகம் விளக்கத்தகம்

11) அறிவும் விளக்கத்தகம் பொறுப்பு விளக்கத்தகம் பொறுப்பிலும் விளக்கத்தம் பொறுப்பிலும்?
    ஆ) காரணம் விளக்கத்தகம்
    இ) விளக்கத்தகம் விளக்கத்தகம்
    க) விளக்கத்தகம் விளக்கத்தகம்
    ம) இந்து விளக்கத்தகம் விளக்கத்தகம்

12) காரணம் விளக்கத்து பொறுப்பு விளக்கத்தகம் அறிவும் விளக்கத்தகம் குறு விளக்கத்து பொறுப்பு விளக்கத்தகம்?
    ஆ) அறிவும் பொறுப்பு விளக்கத்து விளக்கத்தகம்
    இ) அறிவும் பொறுப்பு விளக்கத்து விளக்கத்தகம்
    க) விளக்கத்து விளக்கத்து விளக்கத்தகம்
    ம) இந்து விளக்கத்து விளக்கத்து விளக்கத்தகம்

ஆற்சை விளக்கத்தகம் செல்வது செல்வது செல்வது செல்வது:

13) அறிவும் விளக்கத்தகம் பொறுப்பு விளக்கத்து விளக்கத்து விளக்கத்து விளக்கத்து விளக்கத்து?
    ஆ) இந்து விளக்கத்து விளக்கத்து
    இ) விளக்கத்து விளக்கத்து
    க) இந்து விளக்கத்து
    ம) இந்து விளக்கத்து

ஆற்சை விளக்கத்தகம் செல்வது செல்வது:

14) பொறுப்பு விளக்கத்து பொறுப்பு விளக்கத்து செல்வது? 
    ஆ) இந்து
    இ) விளக்கத்து
15) கொஞ்சுக்கு தெரிகிறது விளக்கித் தொடர்பில் இல்லை அறியல் தேடலா? அவ்வாறு தேடலாம், தெரியலாம் என்கிறீர்க்கு?  
   அ) ஆம. அவ்வாறு தெரிக்கத் தொடர்பில் 5 ஆண்டு என்னும் தொடர்பில்.  
   ஏ) ஆம. அவ்வாறு தெரிக்கத் தொடர்பில் 6-12 ஆண்டுகளும் என்னும் தொடர்பில்.  
   இ) ஆம. அவ்வாறு தெரிக்கத் தொடர்பில் 2 ஆண்டுகளும் என்னும் தொடர்பில்.  
   எ) செய்தியால்.

16) தவறான விளக்கம் வழிப்பட்டிருப்பதா? விளக்கில் இல்லை அறியல் தேடலா?  
   அ) ஆயுதா தெரிக்கத் தொடர்பில் வாத்துதல் என்னும் தொடர்பில்.  
   ஏ) ஆயுதா தெரிக்கத் தொடர்பில் 6 ஆண்டு என்னும் தொடர்பில்.  
   இ) ஆயுதா தெரிக்கத் தொடர்பில் 1 ஆண்டு என்னும் தொடர்பில்.  
   எ) ஆயுதா தெரிக்கத் தொடர்பில் 3 ஆண்டு என்னும் தொடர்பில். 

7) அவ்வாறு தெரிக்கத் தொடர்பில் வாத்துதல் என்னும் தொடர்பில் விளக்கில் இல்லை அறியல் தேடலா?  
   அ) இதற்கான விளக்கம்  
   ஏ) உள்ள விளக்கம் என்னும் தொடர்பில் 
   இ) கேட்கப்பல் பெரியதில் இல்லை. 
   எ) பல விளக்கம்.

18) தொடர்பில் வாத்துதல் என்னும் அவ்வாறு தெரிக்கத் தொடர்பில் வாத்துதல் என்னும் தொடர்பில் இல்லை அறியல் தேடலா?  
   அ) மேலேபொருள்  
   ஏ) நிதிப்பொருள் விளக்கம் அறியல் தேடலாம் 
   இ) குறுக்குப் பொருள் விளக்கம் 
   எ) பிட்செய்தி நெடுந்தனர் விளக்கம் தெளிவாக விளக்கம்.

19) தொடர்பில் வாத்துதல் என்னும் அவ்வாறு தெரிக்கத் தொடர்பில் வாத்துதல் என்னும் தொடர்பில் இல்லை அறியல் தேடலா?  
   அ) 1 ஆண்டு விளக்கம் 
   ஏ) 3 ஆண்டுக்கும் விளக்கம் 
   இ) 24 ஆண்டுக்கும் விளக்கம் 

20) பலவிளக்க பலவிளக்க என்னும் தொடர்பா?  
   அ) ஆயுதா தெரிக்கத் தொடர்பில் 7 ஆண்டுக்கும் விளக்கம் 
   ஏ) ஆயுதா தெரிக்கத் தொடர்பில் 6 ஆண்டுக்கும் விளக்கம் 
   இ) ஆயுதா தெரிக்கத் தொடர்பில் 5 ஆண்டுக்கும் விளக்கம் 
   எ) ஆயுதா தெரிக்கத் தொடர்பில் 12 ஆண்டுக்கும் விளக்கம்

21) தொடர்பில் வாத்துதல் என்னும் அவ்வாறு தெரிக்கத் தொடர்பில் வாத்துதல் என்னும் தொடர்பில் இல்லை அறியல் தேடலா?  
   அ) 1 ஆண்டு விளக்கம் 
   ஏ) 1 ஆண்டுக்கும் விளக்கம் 
   இ) 3 ஆண்டுக்கும் விளக்கம்
22) இப்பட விளையாட்டு அமையாதவர் தீர்வுக்குப் பின் வந்தமாய் காட்டு
அடையாத அப்படிகளில் வேளாண்மை;
அ) காரணங்களா அடையாது
ஆ) காரணங்கள் இன்றுப்போடு
இ) வந்தமாய் திருநோய்கள் அமைந்து;
ஈ) வேளாண்மை காரணங்கள் இன்றுப்போடு;
23) அண்மை தீர்வுக்குப் பின் காரணங்கள் வந்ததாலும் உள்ளது காரணங்களுக்கு
தீர்வுக்குப் பின் வேளாண்மை பெருக்கும்?
அ) 4-6 வேளாண்மை;
ஆ) 6-12 வேளாண்மை;
இ) 12-18 வேளாண்மை;
ஈ) 18-24 வேளாண்மை;
24) அழுதல் தீர்வுக்குப் பின் விளையாட்டு காட்டு வன்மாய் தீர்வுக்கு
பின்னரும் தீர்வுப் பெருக்கும்?
அ) கருப்பு தீர்வுக்கு பின்னரும் தீர்வு;
ஆ) கருப்பு பின்னரும் தீர்வு;
இ) கருப்பு தீர்வுக்கு பின்னரும் தீர்வு;
ஈ) கருப்பு பின்னரும் தீர்வு;
25) காட்டு தீர்வுக்கு தீர்வு காட்டு விளையாட்டு பெருக்கு பொருந்தும்?
அ) 1 வேளாண்மை காட்டு;
ஆ) 45 வேளாண்மைக்கு காட்டு;
இ) 15 வேளாண்மைக்கு காட்டு;
ஈ) 30 வேளாண்மைக்கு காட்டு;
26) அழுதல் தீர்வுக்குப் பின் தரவு காட்டு விளையாட்டு ராமாயாக தீர்வு;
அ) அழுதல் தீர்வுக்கு பின் வந்ததாலும் தீர்வுப்பின்னரும் அழுதல் தீர்வு
பின்னரும் என்பதாலும் தீர்வு;
ஆ) தீர்வுக்கு பின்னரும் என்பதாலும் தீர்வு;
இ) அழுதல் தீர்வுக்கு பின்னரும் வெளியாக தீர்வு;
ஈ) அழுதல் தீர்வுக்கு பின்னரும் என்பதாலும் தீர்வு;
27) இப்பட விளையாட்டு அமையாதவர் தீர்வுக்குப் பின் வந்தமாய் காட்டு;
அ) அழுதல் தீர்வுக்கு பின்னரும் தீர்வு;
ஆ) அழுதல் தீர்வுக்கு பின்னரும் தீர்வு;
இ) அழுதல் தீர்வுக்கு பின்னரும் தீர்வு;
ஈ) அழுதல் தீர்வுக்கு பின்னரும் தீர்வு;
28) அழுதல் தீர்வு காட்டு விளையாட்டு பெருக்கு பொருந்தும்?
அ) அழுதல் தீர்வுக்கு பின் வந்ததாலும் தீர்வு;
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29) மேற்பரப்புக்கும் பின் பதவு பாதுகாப்பதற்கு காண்பால் விளக்கம்?
   அ) 1 பாதுகாப்புப் பிரிவு.
   ஆ) 1 பாதுகாப்புப் பிரிவு.
   இ) 2 பாதுகாப்புப் பிரிவு.
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30) மேற்பரப்பு மற்றும் அடுக்கு விளக்கம் சிக்கும் வேண்டும் வழங்களைக் கொண்டு மேற்பரப்பு உண்மையான வழங்கல்களை வாத்து விளக்கம்?
   அ) மேற்பரப்பு அடுக்கு வழங்கல்
   ஆ) மேற்பரப்பு உண்மையான வழங்கலை குறிப்பிட்டு அடுக்கு வழங்கல்
   இ) குறிப்பிட்டு, பாதுகாப்பின் அடுக்கு, பாதுகாப்பு அடுக்குகளை மேற்பரப்பு வழங்க வழங்கல்
   ஈ) மேற்பரப்பு அடுக்கு வழங்கல்

சுருக்கலாம் பகுதிகள்: 1) வ, 2) வ, 3) அ, 4) அ, 5) அ, 6) அ, 7) அ, 8) அ, 9) அ, 10) அ, 11) அ, 12) அ, 13) அ, 14) அ, 15) அ, 16) வ, 17) வ, 18) வ, 19) அ, 20) அ, 21) அ, 22) வ, 23) அ, 24) அ, 25) அ, 26) அ, 27) அ, 28) அ, 29) அ, 30) வ.
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<tr>
<th>கருத்துக்கள்</th>
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செயல்பாடு கருத்துக்கள்: 1,4,5,7,10, கருத்துக்கள் நடைபெற்றது: 2,3,6,8,9.
VIDEO TEACHING ON TOTAL HIP REPLACEMENT. (LESSON PLAN)
Place : MIOT Hospitals.

Topic : Total hip replacement.

Language : Tamil and English

Duration : 40 Minutes

Learners : Patients undergoing Total Hip Replacement.

Teacher : Selvi.k. II year M.Sc (N)

Method of teaching : Lecture

Audio visual aid : Video Assisted Teaching

CENTRAL OBJECTIVES

The Patients will be able to understand and gain knowledge about Total Hip Replacement, causes, clinical manifestation, diagnosis, complication, management, also develop desirable attitude towards the management of Total Hip Replacement.

BEHAVIOURAL OBJECTIVES

The Patient Undergoing Total Hip Replacement will be able to

- describe anatomy and physiology of Hip Joint.
• explain the degenerative hip disorders.
• list down the conditions requiring a hip replacement.
• enlist the signs and symptoms of degenerative hip disorders.
• outline the investigations done prior to THR.
• paraphrase the pre-operative care of the patient undergoing THR.
• elucidate the surgical procedure of THR.
• recall the post – surgical complications of THR.
• explain the exercise programme
• enumerate the home preparation before returning to home.

INTRODUCTION: Good morning I am Selvi.k doing my M.Sc (N) second year in MIOT College of nursing. I am doing a research on knowledge, attitude, and practice among patients undergoing Total Hip Replacement. So we will discuss about Total Hip Replacement through video Assisted Teaching Module.
<table>
<thead>
<tr>
<th>BEHAVIOURAL OBJECTIVES</th>
<th>CONTENT</th>
<th>TEACHERS ACTIVITY</th>
<th>LEARNERS ACTIVITY</th>
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</table>
| The Patient Undergoing Total Hip Replacement will be able to | **ANATOMY AND PHYSIOLOGY OF THE HIP JOINT.**  
The hip joint is a ‘ball and socket’ joint. The hip joint allows movement to occur between the thigh bone (Femur), and the hip bone (Pelvis). The pelvis contains the ‘socket’ called the acetabulum. The ball shaped head of the femur fits into the acetabulum, forming a ball and socket joint which enables the leg to have a wide range of movements. The outer surface of the femoral head and the inside surface of the acetabulum are covered with cartilage. The cartilage surface is a tough, very smooth material that allows the two surfaces to slide against one another during movement with ease. | Explaining | Listening |
| - describe anatomy and physiology of Hip Joint. | | | |
| | **DEGENERATIVE HIP BONE DISEASE:**  
A degeneration or ‘wear and tear’ of articular (joint surface) cartilage usually accompanied by an overgrowth of bone (osteophytes), narrowing of the joint space, sclerosis or hardening of bone at the joint surface, and deformity in joints. The hip bone is the connecting point for the thigh bone and pelvis bone. If the cartilage is not properly repairing itself while wearing away from the hip bone, the result is degenerative hip bone disease. | Explaining | Listening |
| - explain the degenerative hip disorders | | | |

xxxi
- list down the conditions requiring a hip replacement

**CONDITIONS REQUIRING A HIP REPLACEMENT:**

- Osteoarthritis: That is commonly referred to as ‘wear and tear arthritis’.
- Avascular necrosis: The femoral head (ball) loses a portion of its blood supply and actually dies. This leads to collapse of the femoral head and degeneration of the hip joint.
- Trauma to the hip.
- Fracture of the hip.

Congenital dysplasia of the hip: A type of hip conditions that appear in childhood, can lead to degeneration many years later.

- enlist the signs and symptoms of degenerative hip disorders.

**SIGNS AND SYMPTOMS OF DEGENERATIVE HIP DISORDER.**

- Painful mobility and restricted hip movement
- Joint stiffness.
- Coarse crepitus (a creaking or cracking) may be felt in the joint.
- Mild joint swelling and tenderness to touch.
- The joint may feel warm.

- outline the investigations done prior to THR.

**INVESTIGATIONS DONE PRIOR TO THR.**

1. Fitness to have an anesthetic:
   - Complete blood count
   - Blood sugar (Random)
<table>
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<tr>
<th><strong>Blood Urea</strong>&lt;br&gt;<strong>Serum Creatinine</strong>&lt;br&gt;<strong>Serum electrolytes</strong>&lt;br&gt;<strong>Platelet count</strong>&lt;br&gt;<strong>PT/APTT</strong>&lt;br&gt;<strong>Chest x-ray</strong>&lt;br&gt;<strong>ECG / EKG</strong>&lt;br&gt;<strong>Routine urine examination</strong>&lt;br&gt;<strong>Echo cardio gram ( for patients above 45 years)</strong></th>
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<tr>
<td>2. To detect hidden infection :&lt;br&gt;<strong>Urine culture</strong>&lt;br&gt;<strong>Dental opinion</strong>&lt;br&gt;<strong>Dermatologist consultation</strong></td>
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<td>3. Technical planning :&lt;br&gt;<strong>AP &amp; lateral x rays of your affected hip and AP of the pelvis with both hips.</strong></td>
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<td>4. May be required:&lt;br&gt;<strong>CT scan &amp; 3D reconstruction</strong></td>
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<td>5. <strong>Doctor’s assessment</strong>&lt;br&gt;Urologist opinion in elderly males.&lt;br&gt;Cardiologist opinion in high risk patients&lt;br&gt;Gynecologist opinion for females.</td>
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- Paraphrase the pre-operative care of the patient undergoing THR.

**THE PRE-OPERATIVE CARE OF THE PATIENT UNDERGOING THR.**

- Informed consent should be obtained.
- Anesthetist opinion should be obtained.
- Follow the doctor’s instructions regarding use of medication in the days leading to surgery.
- Clopilet & warfarrin medications should not
be taken 10 days prior to surgery.  
- Nutritional supplements like vitamin E should be stopped 10 days prior to surgery.  
- Do not eat or drink after midnight.  
- Try to get long, restful nights of sleep.  
- Patient should take chlorehexidine shower and wear hospital gown in the morning on the day of surgery.

<table>
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<th>elucidate the surgical procedure of THR.</th>
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**SURGICAL PROCEDURE.**  
There are a number of ways in which the pain in the hip can be relieved. These can include changes in lifestyle or taking pain relieving medications. Another option is an operation to replace the hip joint. Replacing the hip joint is usually recommended when the pain becomes so constant that it is limiting everyday activities.

**THE AIM OF HIP REPLACEMENT SURGERY IS TO:**

- Relieve the pain.  
- Correct any deformity for example, leg length inequality.  
- Restore any loss of function of the Hip.  
- Improve the quality of life.

**COMPONENTS OF A HIP REPLACEMENT:**

Hip joint replacement surgery involves replacing the head of the femur (ball) and the acetabulum (socket) with manmade components,
called prostheses. The hip prostheses are designed to stimulate the human anatomy as closely as possible. Depending on the damage of the hip, the surgeon may decide to give a total hip replacement or a hip resurfacing procedure. There are many different designs of hip prosthesis available and the surgeon will choose the one considered most suitable for the patient.

COMPONENTS OF A HIP REPLACEMENT:

Each hip prosthesis is made up of several parts:

1. The acetabular component or cup replaces the acetabulum. The acetabular component can either be made of a metal alloy outer shell with a fitted plastic, metal or ceramic liner or it can be made of a one plastic component.
2. The femoral component replaces the femoral head. The femoral component can be a single or a two piece design. The single piece is made of metal alloy, while the two piece design consists of the femoral stem, made of metal alloy and the femoral head that attaches to the stem which can be made of either ceramic or metal alloy. This is known as a modular prosthesis.

Envelops of tough ligaments connect the pelvis and femur, covering the joint and stabilizing it. The hip joints’ movements are initiated and controlled by the thick muscles of the buttock at the back and
the thick muscles of the thigh at the front. A healthy hip joint will allow the leg to move freely within its range of motion, while supporting the upper body and absorbing the impact that results from activities such as walking and running.

- recall the post – surgical complications of THR.

**POST SURGICAL COMPLICATIONS OF THR:**
- Deep vein Thrombosis or Venous Thromboembolism.
- Dislocation of the hip joint.
- Infection of the Joint.
- Loosening of the joint.

- explain the exercise programme

**EXERCISE PROGRAMME AND PHYSIOTHERAPY:**
- Ankle pump Exercise.
- Knee Isometric Exercise.
- Buttocks Isometric Exercise.
- A wedge pillows will be placed in-between the legs to hold them in correct position.
- Getting out of the bed.
- Sitting on the chair.
- Do not bend the body forward excessively.
- Sit with both feet on the floor and the knees about 10cm apart.
- Do not cross the legs.
- Do not stand with the operated legs facing
inward or outward.

- Turn with both of the feet and the body.
- Do not turn on the operated leg.
- Do not bend all the way down to pick up things from the floor.

- **Climbing the staircase**: Once after the patient start walking independently he/she can start climbing the staircase from the 5th post operative day itself.

**Getting in and out of the car**: Once after you get discharge from the hospital to get into the car. You should bring your non operated leg first and then your operated leg next. Both legs should be parallel while bringing into and out of the car.

**SUTURE REMOVAL**: Wound sutures or staples are usually removed on the tenth to fourteenth day after surgery.

- enumerate the home preparation before returning to home.

**PREPARING FOR HOME BEFORE THE PATIENT RETURN TO HOME**: Since the patient will be spending a lot of time at home following surgery and the movements and activities will be restricted, it is important that the patient should arrange the furniture and household items ahead of time to maximize the comfort and convenience during rehabilitation.

- Add extra cushions to couches and chairs for comfort and to ensure that the patient will be sitting high enough to accommodate his/her new hip during your rehabilitation period.
- Since the patient should avoid bending the hip past 90 degrees, it is important that he/she not sit in a way that will bend the waist lower than the knees.
- Cover or remove all chairs without arms. During rehabilitation, the patient should only sit in armchairs, as he/she will need the arms to help you sit down and get up.
- Arrange to have an elevated toilet seat and/or support bars fitted in the bathroom when it is time to leave the hospital.
- Remove all throw rugs and anything else on the floor that it might cause the patient to slip or trip.

| • describe the home management after discharge. | DIET PLAN: Calorie rich, iron rich and calcium rich supplements should be included in the diet. | ALLOWABLE ACTIVITIES AFTER HIP REPLACEMENT:
|✓ The patient can walk as much as he/she likes. | ✓ The best recommended activities are walking and swimming. | ✓ The patient can have ballroom dance, play golf and ride a stationary or mobile bike. |
|SEXUAL ACTIVITY: | For the first four to six weeks after surgery, the patients are discouraged from participating in sexual relations. Return to normal sexual activity should therefore be gradual after 10 to 14 days. | Explaining | Listening |

xxxviii
RETURN APPOINTMENT:
After one month of discharge from the hospital. This visit will consist of a clinical and X-ray evaluation. The next phase of your rehabilitation will be outlined.

CONCLUSION:
So far u was watching the video programme regarding THR. I hope u would have acquired adequate knowledge about THR.
APPENDIX - E

VIDEO ASSISTED TEACHING MODULE - ENGLISH

ANATOMY AND PHYSIOLOGY OF THE HIP JOINT
The hip joint is a ‘ball and socket’ joint.
The hip joint allows movement to occur between the thigh bone (femur) and the hip bone (pelvis).
The pelvis contains the ‘socket’ called the acetabulum.

DEGENERATIVE HIP BONE DISEASE
A degeneration or ‘wear and tear’ of articular (joint surface) cartilage usually accompanied by an overgrowth of bone.

CONDITIONS REQUIRING A HIP REPLACEMENT
OSTEOARTHRITIS:
Referred as ‘Wear and Tear arthritis’

AVASCULAR NECROSIS:
The femoral head (ball) loses a portion of its blood supply and actually dies.

ANKYLOSING SPONDYLITIS:
It affects the cartilaginous joints of the spine and surrounding tissues. Occasionally the large synovial joints such as hips, knees or shoulders may be involved.

TRAUMA TO THE HIP OR FRACTURE OF THE HIP:

CONGENITAL DYSPLASIA OF THE HIP:
A type of hip conditions that appear in childhood, can lead to degeneration many years later.
SIGNS AND SYMPTOMS OF DEGENERATIVE HIP DISORDER
Painful mobility and restricted hip movement joint stiffness.
Coarse crepitus (a creaking or cracking) may be felt in the joint.
Mild joint swelling and tenderness to touch.
The joint may feel warm.

INVESTIGATIONS DONE PRIOR TO THR.
FITNESS TO HAVE AN ANESTHETIC:
- Blood test
- ECG
- ECHO
- The Confirmatory test done before Total Hip Replacement is radiological studies such as X-Ray, C.T, or MRI.

TO DETECT HIDDEN INFECTION
- Urine culture
- Dental Opinion
- Dermatologist consultation

DOCTOR'S ASSESSMENT:
- Urologist opinion in elderly males.
- Gynaecologist opinion for females.
- Cardiologist opinion in high risk patients.

PRE-OP PROCEDURES
Informed consent should be obtained.
Anesthetists opinion should be obtained.
Follow regular diet the day before the surgery.
Follow the doctor’s instructions regarding use of medication in the days leading to surgery.
Clopiglet and warfarin medications should not be taken 10 days prior to surgery.

Nutritional Supplement like vitamin E should be stopped 10 days prior to surgery.
Do not eat or drink after midnight.
Instruct the patient to get long, restful nights of sleep.
Patient should take chlorexidine shower and wear hospital gown.
Pre medication and antibiotics must be administered.

SURGICAL PROCEDURE
Hip joint replacement surgery involves replacing the head of the femur(ball) and the acetabulum (socket) which forms an artificial hip joint.
**COMPONENTS OF A HIP REPLACEMENT**

Each hip prosthesis is made up of several parts:

- The acetabular component or a cup replaces the acetabulum. The acetabular component can either be made of a metal alloy, outer shell with a fitted plastic, metal or ceramic liner or it can be made of a one plastic component.
- The femoral component replaces the femoral head. The femoral component can be a single or a two piece design.

The single piece is made of metal, while the two piece design consists of the femoral stem, made of metal alloy and the head that attaches to the stem which can be made of either ceramic or metal alloy (titanium). This is known as a modular prosthesis.

**POST SURGICAL COMPLICATIONS OF THR**

- Deep vein thrombosis or venous thromboembolism.
- Infection in the joint.
- Dislocation of the joint.
- Loosening of the joint.

**EXERCISE PROGRAMME AND PHYSIOTHERAPY**

**ANKLE PUMP EXERCISE**

It helps to reduce swelling and risk of blood clots in your legs. Do about 10 to 20 times every hour when you are awake.

**KNEE ISOMETRIC**

- Lie on your back with the legs straight.
- Tighten your thigh muscles thinking as you do so that you are pushing your knee into the bed.
- Hold the contraction for 5 counts and then release.
- Do this 5 times.
**BUTTOCK ISOMETRIC EXERCISE:**

While lying, squeeze your buttock muscles together for a count of 5 and then release.

Do this 5 times.

---

**A WEDGE PILLOW**

Will be placed in between your legs to hold them in abduction position.

Use abduction pillows for 4-6 weeks.

You should not turn any side and should not rotate your legs inward or outward.

You should lie in supine position for 1 month.

Do not raise the knee higher than the hip.

---

**GETTING OUT OF THE BED:**

**Step 1:**

You have to move sideways to the edge of the bed by lifting the hip.

---

**Step 2:**

Should get up straight away by pressing the elbow towards the bed.

**Step 3:**

The therapist will help you by holding your leg, you have to push up yourself by lifting bottom and rotate slowly.

---

**Step 4:**

Get down by placing the operated leg first then non operated leg.

---

**SITTING ON CHAIR:**

The chair Height should be 17” maximum.

Should use cushion underneath while sitting.

The chair should have arm rest and back rest.
While sitting avoid forward bending excessively. Should not flex the knees beyond 90 degrees. Sit with both feet on the floor and your knees about 10cm apart. Avoid combinations of movement with the new hip. For example, do not sit with the legs crossed.

Do not sit on low chairs, sofas, beds, or toilet seat temporarily.

Do not bend over more than 90 degrees. This means do not bend down to tie the shoes for a while.

The patient can start walking with the help of the Physiotherapist with in 1 hour after surgery it depends upon the condition of the patient.

PARALLEL BAR WALKING:
You have to walk inside parallel bar for the first 3 days and then start crutch walking.

CLIMBING THE STAIRCASE:
Once after the patient start walking independently he or she can start climbing the staircase from the 5th post operative day itself.

GETTING IN AND OUT OF THE CAR:
Once after you get discharge from the hospital, to get into the car, you should bring your Non operated leg first and then your operated leg next.

When getting out of the care you have to bring your operated leg first and then your Non operated leg next. Both leg should be parallel while bringing into and out of the car.

HIP PRECAUTION:
Do not stand with your operated leg facing inward or outward. Flexion with internal rotation of the hip is the dangerous position, to move the hip after THR.
**SUTURE REMOVAL:**
Wound sutures or staples are usually removed on the tenth to fourteenth day after surgery.

**PREPARING FOR HOME BEFORE THE PATIENT RETURN TO HOME:**
Add extras cushions to couches and chairs for comfort and to ensure that the patient will be sitting high enough to accommodate his/her new hip during your rehabilitation period.

Since the patient should avoid bending the hip 90 degrees, it is important that he/she not sit in a way that will bend the waist lower than the knees.

Arrange to have an elevated toilet seat and/or support bars fitted in the bathroom when it is Time to leave the hospital.

Remove all slippery floor mats and anything else on the floor that might cause the patient to slip or trip.

**DIET PLAN:**
Patient under gone Total Hip Replacement can have normal diet unless they have any restriction.

More amount of water intake is advisable.

Patient who had neck of femur fracture is advised to take calcium rich diet.
ALLOWABLE ACTIVITIES AFTER HIP REPLACEMENT:
The Patient can walk as much as he/she like.
The patient can swim, ballroom dance, play golf after 3 months.

SEXUAL ACTIVITY:
For the first four to six weeks after surgery, the patients are discouraged from participating in sexual relations. Can return to normal sexual activity after one month.

RETURN APPOINTMENT:
After one month of discharge from the hospital. This visit will consist of a clinical and x-ray evaluation.

Thank You!
RESEARCHER ADMINISTERING VIDEO MODULE.

OBSERVING THE PRACTICE OF EXERCISE.