the specialist needs of frail patients gives geriatric day hospital a distinct edge over any other outpatient service.

Our experience of establishing a heart failure service for elderly patients based in the day hospital is an example of an innovative use of this resource. Elderly patient with possible heart failure were referred to the outpatient clinic but the patients had to make three to four hospital visits prior to confirmation of diagnosis and it took at least 6 weeks. Walking through long hospital corridors and visiting different departments was beyond the capability of many frail patients. However, concentrating services in the day hospital with in-house facility for echocardiography, respiratory function test, phlebotomy and close working relation with the X-ray department led to the diagnosis being confirmed and treatment commenced or changed on the very first visit. The day hospital environment and availability of multi-disciplinary rehabilitation complemented this service as many frail patients with heart failure had unmet rehabilitation needs.

The future of geriatric day hospital is bright provided its role changes with the changing needs of the elderly population. It should maintain its traditional role but should offer new flexible services for frail elderly patients; the possibilities are endless. As the working of the geriatric day hospital is changing, it may be prudent to rename this facility. Elderly Medical Assessment Unit will be more realistic and will help to change its image.

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The effect of bedrails on falls and injury

SIR—Healey et al. [1] are to be congratulated for their review of the use of bedrails. I agree with their balanced conclusions that health care organisations should be encouraged to reduce inappropriate use of bedrails, rather than a universal reduction. Their review also highlights the conflicting and very limited evidence both for and against bedrail use.

However, the authors omitted another negative aspect of bedrails, namely that bedrails may be a barrier to rehabilitation and getting out of bed. The physical presence of bedrails, even in the ‘down’ position, makes it more difficult and takes longer for an elderly person to get out of bed [2]. The most likely reason for this is the physical depth of the bedrail which extends beyond the mattress edge. When the bedrail is in the ‘up’ position, egress from bed to go to the toilet is even more difficult!

Older people in hospital are generally frail, at risk of deconditioning and have the least reserves [3]. They need every advantage to get better in hospital, with minimisation of any barriers that impede effective rehabilitation. Physically removing inappropriate bedrails from the bed may help.

Whilst use of bedrails seems embedded in our health culture, it should not encourage complacency. Healey’s review has shown that bedrails do not cause more harm by increasing falls or fall-related injury, but there is still a disturbing lack of evidence showing that bedrails work (i.e. reduce risk of falls). If bedrails have not been shown to be effective and they impede egress from bed, then that is harmful albeit in a less obvious way.

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