SYDÄMEN VAJAATOIMINTA – OHJAUSVIDEO POTILAALLE

Guidance Video for Heart Failure Patients

Milla Moilanen

Kaisa Vuorinen

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Tampere University of Applied Sciences

ABSTRACT

Tampereen ammattikorkeakoulu
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MOILANEN, MILLA & VUORINEN, KAISA:
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Heart failure is an increasing condition as the population grows older and the treatment of heart related problems improve. Effective patient guidance is the key factor in the successful treatment of heart failure. Successful guidance improves patient adherence to treatment and diverse guidance material should be used to reach this goal.

The purpose of this functional thesis was to create an efficient and an empowering guidance video to patients with a recently diagnosed heart failure. The video was commissioned by a cardiac ward B5 from Hatanpää Hospital. The aim was to provide heart failure patients and their significant others with a guidance video and to produce an efficient guiding tool for nurses. The theory consists of our key concepts heart failure, efficient patient guidance, and a DVD/video as a guiding material. The guidance video features clear visual information about heart failure and the most important aspects of treating heart failure in a nutshell. It will also be available for patients through Hatanpää Hospital's website.

For the future, it would be beneficial to conduct a research about knowledge gaps among heart failure patients. Also producing shorter video clips dividing all the sections of the treatment into smaller but deeper information packages would benefit the heart failure patients.

Key words: heart failure, chronic heart failure, patient education, self-care, patient guidance video.

TIIVISTELMÄ

Tampereen ammattikorkeakoulu
Hoitotyön koulutusohjelma
Sisätauti-kirurginen suuntautuminen

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Guidance Video for Heart Failure Patients

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Sydämen vajaatoiminta yleistyy väestön vanhetessa ja sydämeen liittyvien sairauksien hoidon parantuessa. Sydämen vajaatoiminnan tehokkaaseen hoitoon olennaisena osana kuuluu tehokas potilasohjaus. Onnistunut potilasohjaus parantaa potilaan hoitoon sitoutumista. Tämän tavoittamiseksi tulisi käyttää monimuotoisia ohjausmateriaaleja.

Tämän toiminnallisen opinnäytetyön tarkoituksena oli tuottaa tehokas ja voimaannuttava ohjausvideo potilaille joilla on juuri todettu sydämen vajaatoiminta. Tilauksen antoi osasto B5 Hatanpään sairaalasta. Tavoitteena oli luoda sydämen vajaatoimintapotilaille ja heidän läheisilleen ohjausvideo, sekä saada aikaan tehokas työkalu sairaanhoitajille potilaan ohjaukseen. Opinnäytetyön teoria koostuu keskeisistä käsitteistä jotka ovat sydämen vajaatoiminta, tehokas potilasohjaus ja DVD/video ohjausmateriaalina. Ohjausvideo sisältää selkeää visuaalista tietoa sydämen vajaatoiminnasta ja sen tärkeimmät hoitomuodot pähkinänkuoressa. Ohjausvideo tulee olemaan potilaiden käytössä myös Hatanpään sairaalan verkkosivujen kautta.

Jatkotutkimuksia ajatellen hyödyttäisi tutkia sydämen vajaatoimintapotilaiden puutteita tautiin liittyvissä tiedoissa. Sydämen vajaatoiminta potilaita hyödyttäisivät myös videot joissa hoidon eri osa-alueet esitettäisiin lyhyemmin mutta käsitellen aihetta syvemmältä.

Asiasanat: sydämen vajaatoiminta, krooninen sydämen vajaatoiminta, potilasohjaus, itsehoito, potilaan ohjausvideo.

CONTENTS

1 INTRODUCTION

Heart failure means that the heart cannot pump the blood efficiently to the body and organs. It is a syndrome that can be caused by many different heart diseases such as high blood pressure, coronary disease and valvular diseases. (Lommi 2013.) Heart failure can be seen as a modern epidemic that influences our society (Boyde, Tuckett, Peters, Thompson, Turner & Stewart 2009, 2030-2031). As aging of the population occurs, the number of patients with heart failure increases. In Finland approximately 5% of the over 65 year olds suffer from heart failure. (Lommi 2013.)

Heart failure creates an economic and human burden, and the awareness of this burden has led to an increased effort to maximize the health outcomes for the heart failure patients. For a positive health outcome to happen, knowledge has to be obtained, adapted and behavior changed. Educating patients in healthcare is an active and individualized process. (Boyde et al. 2009, 2030-2031.) Adult learners benefit the most when information is combined in a visual, auditory and kinesthetic way (Russell 2006, 352). Heart failure patients prefer short and simple information that gives basic explanations in layman's terms and without medical jargon (Boyde et al. 2009, 2036).

The purpose of our Bachelor's thesis was to create a guidance video for patients with recently diagnosed heart failure and their significant others. This topic was suggested by cardiac ward B5 from Hatanpää Hospital to renew their outdated guiding material. This topic was chosen because we wanted to produce something usable and beneficial to the community while providing an educational tool for nurses. Our aim was to produce target oriented material which is audio-visually high quality, educational, to the point, clear and from a patient's point of view. The video is spoken in Finnish.

The terms heart failure, chronic heart failure and congestive heart failure all mean the same condition, but vary in the theory according to the origin of the study. We chose to use the term heart failure (HF) throughout the thesis because as a direct translation from Finnish it feels more natural to us.

2 PURPOSE AND OBJECTIVES OF BACHELOR'S THESIS

The purpose of this functional thesis was to create a 10-15 minutes long guidance video about heart failure to patients who are recently diagnosed with heart failure and to educate them about the new aspects of their life after diagnosis. The video portraits the following issues:

1) What is heart failure?
2) What are the life changes that need to be taken into consideration?
3) How can the symptoms be managed and when to seek professional help?

The objective of this thesis was to produce a guidance video that benefits the patients with heart failure, their significant others and the nurses who will have a new audiovisual material to use in guidance. We also wanted to educate ourselves about guiding patients, heart failure and about making a functional Bachelor's thesis.

3 HEART FAILURE

3.1 What is heart failure?

The heart is a muscle that pumps blood into circulation. It consists of two halves; the left side and the right side. The left ventricle pumps blood into the systemic circulation where the blood returns to the right atrium and passes on to the right ventricle. Right ventricle pushes the blood into the pulmonary circulation where the blood oxygenates and returns to the left atrium and from there back to the left ventricle. (Kettunen 2011.) When the heart works correctly, this function operates sufficiently to supply oxygen and nutrients to the body and organs (The Impact of Congenital Heart Defects 2012). When the blood is not circulating adequately in the body, the kidneys do not receive enough blood to filter fluid into urine and the fluid is congested in the lungs, liver and/or the legs (Congestive Heart Failure 2011).

Heart failure (HF) is a progressive disease that 1-2% of the population in Finland is suffering from. The average age of the patients is 76 years. The incidence of heart failure increases along with ageing. (Heikkilä, Kupari, Airaksinen, Huikuri, Nieminen & Peuhkurinen 2008, 715.) Altogether HF means that the cardiac muscle is not working sufficiently to pump the blood to the body and organs. Heart failure is not a disease in itself, but a symptom that can be a result from many different heart diseases. The most common reasons for heart failure are coronary disease, high blood pressure, heart attack, and atrial fibrillation. Other reasons can be heart muscle damage due to infection, cardiomyopathy, excessive use of alcohol, or mechanical dysfunctions such as a damaged cardiac valve. (Mustajoki 2012.) HF is characterized as a clinical syndrome that causes shortness of breath, edema, or fatigue due to fluid overload and insufficient tissue perfusion. HF is commonly a progressive, life-long condition that is managed with medication and permanent life-changes to prevent episodes of heart failure exacerbations. (Smeltzer, Bare, Hinkle & Cheever 2010, 825.)

As heart failure develops and the deficiency of pumping the blood to the body emerges, the body creates neurohormonal compensation mechanism that can worsen the function of the heart even further (Lommi 2008; Smeltzer et al. 2010, 826). These mechanisms

develop as an attempt of the body to cope with the heart failure (Smeltzer et al. 2010, 826). As the minute volume of the heart diminishes and the tissue perfusion decreases, the sympathetic nervous system increases the frequency of contractions of the heart and therefore the pulse rate increases, trying to supply the needed oxygen and nutrients. The preload and afterload of the heart are increased, which leads to an increased workload for the heart. This results in myocardial cell stretching, ventricular dilatation and in thickening of the heart muscle (ventricular hypertrophy). These compensatory mechanisms secure the needed tissue perfusion and heart's sufficient pumping. If the damage of the muscle is too great or the compensatory mechanisms are not enough, then the symptoms of heart failure will occur. (Heikkilä et al. 2008, 719-721; Smeltzer et al. 2010, 826-827.)

Heart failure can be divided into systolic or diastolic type and to left-sided or right-sided failure. Left-sided heart failure is more common and is a result of the left side being impaired to pump the blood to the body. This increases the pressure in pulmonary circulation and damages the right ventricle, which can lead to right-sided heart failure. In right-sided heart failure the right ventricle insufficiently pumps blood to the pulmonary circulation which leads to the accumulation of fluids to the lower extremities' blood vessels and tissues. (Types of Heart Failure 2012.)

In diastolic heart failure the left ventricle's dilatation and filling during diastole are impaired due to the heart muscle being stiff and noncompliant. Diastolic heart failure is usually a result from left ventricular hypertrophy, hypertension, high age, coronary disease, or cardiomyopathy. Impaired diastolic filling of the left ventricle leads to the stress of the pulmonary circulation and even to pulmonary edema. (Heikkilä et al. 2008, 719-720, 770-771; Lommi 2008; Smeltzer et al. 2010, 825.) In systolic heart failure, blood volume that is ejected from the left ventricle is decreased. This can be a result of loss of well-functioning myocardial cells due to ischemic heart diseases, hypertension, valvular dysfunctions, or arrhythmias. (Heikkilä et al. 2008, 719-720; Lommi 2008; Types of Heart Failure 2010.)

The symptoms of heart failure are abnormal fatigue, increased pulse rate, shortness of breath (dyspnea), dry cough when lying down, weight gain, swellings, and loss of appetite (Partanen & Lommi 2011; Mustajoki 2012). The most common symptom of heart failure

is dyspnea which occurs mainly after exercise, but can also occur while resting. Heart failure can lead to pulmonary edema where dyspnea increases quickly and occurs also when lying down. (Mustajoki 2012.) When the minute volume of the heart has diminished and the renal circulation decreased, the kidneys are not able to filter fluids effectively out of the blood. Commonly swelling around the ankles and shins occurs as the result of fluid accumulating in the tissues. This also occurs because of increased systemic venous pressure causing the fluids to move from capillaries to tissues. (Heikkilä et al. 2008, 734; Mustajoki 2012.) Heart failure causes damage to bones and muscles which explains fatigue as one leading symptom of the heart failure (Heikkilä et al. 2008, 734).

Heart failure can be divided into chronic and acute failure. In chronic heart failure the disease progresses slowly and symptoms develop gradually, whereas acute heart failure is caused by a sudden heart illness which leads to dysfunction of left ventricle and the symptoms emerge rapidly. Acute heart failure can be a result from myocardial infarction, myocarditis, rupture of a valve, arrhythmia, or the sudden exacerbation of chronic or undiagnosed heart failure. (Heikkilä et al. 2008, 714.) When the function of left ventricle suddenly deteriorates, the blood volume and pressure in the left ventricle increases leading to a decreased pulmonary circulation. The pressure in pulmonary veins grows and fluid from pulmonary capillaries pushes through to pulmonary tissues and alveolies, causing pulmonary edema, impaired gas exchange, and therefore severe breathing difficulties. (Smeltzer et al. 2010, 828.) Acute heart failure always needs hospital care but can be effectively treated, and the symptoms ease out quickly with the right treatment. However, it is usual that acute heart failure leads to chronic disease and the patient will need a life-long medication. (Heikkilä et al. 2008, 714-715).

Chronic heart failure means that the heart is permanently unable to maintain an adequate circulation to organs (Lommi 2008). The most common causes of heart failure are coronary disease and cardiac muscle defect which is caused by hypertension. Many patients also have diabetes, anemia and renal failure. The symptoms of chronic heart failure usually develop gradually. At first, the patient has difficulties in breathing and fatigue only from time to time after heavy exercise. Therefore the patient might not identify the condition as the heart failure. When the disease develops, these symptoms start to emerge after only mild physical activity and gradually also at rest. (Heikkilä et al. 2008, 714-715.)

The prognosis of heart failure is usually weak. The condition develops at the end-stage of heart diseases resulting to high morbidity and mortality. (Heikkilä et al. 2008, 717; Smeltzer et al. 2010, 814.) The prognosis is worse amongst male than females. Despite the ageing of the population and that the mortality rates have increased, the prognosis of heart failure has improved, especially amongst men. (Heikkilä et al. 2008, 717-718.) According to Lommi (2008), with well implemented medication treatment and life changes the symptoms can be effectively alleviated and the prognosis improved.

3.2 Treatment of heart failure

The treatment of HF is multifaceted and combines pharmacological and non-pharmacological ways. Non-pharmacological ways are low sodium diet, restricted fluid intake, exercising, weight monitoring, and smoking cessation. (Searson 2007, 54-56.) Because heart failure can be a result from many different heart diseases, the treatment of HF is chosen depending on the symptoms and the quality and the contributors of the heart failure. The aim of the pharmacological treatment is to ease the symptoms, improve physical capacity, and prevent the progression of HF. Sometimes invasive procedures are included in the treatment, such as placing a pacemaker, repairing the heart valve, or even performing a heart transplantation. (Heikkilä et al. 2008, 754.) The progression of heart failure can be slowed down by following a healthy lifestyle that diminishes the onset of coronary disease and high blood pressure, since they are the most common causes for HF (Mustajoki 2012). Patients' adherence to treatment is the single most important challenge the healthcare professional faces in the management of HF and related conditions (Turpin, Simmons, Lew, Alexander, Dupee, Kavanagh, & Cameron 2004, 378). In a study conducted by Hope, Wu, Tu, Young and Murray (2004, 49), it was found that education given about medication knowledge and skills reduced emergency department visits in patients 50 years of age or older with HF, which highlights the importance of good quality patient education. The patients should know how to recognize the alarming signs and symptoms of heart failure and when to contact health care professionals (Smeltzer et al. 2010, 830).

3.2.1 Medication

Heart failure is treated in a pharmacological way with several medicines that are taken regularly by mouth. The aim of the medication treatment is to prevent the progression of the disease, to restrain neuroendocrine activity, to alleviate the systolic workload by reducing preload and afterload, and to prevent myocardial ischemia. (Heikkilä et al. 2008, 758; Smeltzer et al. 2012, 829.) The most important medication includes diuretics, angiotensin-converting enzyme inhibitors (ACE-inhibitors), angiotensin receptor blockers (ATR-blockers), and beta-blockers (Mustajoki 2012). According to Current Care Guidelines (Kohonnut verenpaine: Käypä hoito-suositus 2009), treatments which are based on medicines like ACE-inhibitors, ATR-blockers, beta-blockers, diuretics, or calcium channel blockers diminish possible heart problems.

Diuretics can be prescribed even if the diagnosis of heart failure is not completely assured, but there are obvious symptoms of HF (Heikkilä et al. 2008, 758). Diuretics remove the excess fluid from the body increasing the urine production and decreasing the edema and body weight (Smeltzer et al. 2012, 831). Due to increased urine production and possible sleep disturbances, diuretics are recommended to be taken at least five hours before going to sleep (Partanen 2011). Diuretics also excrete potassium which is why the patients need to monitor their serum potassium levels regularly. Diuretics are mainly used in severe heart failure in combination with other medication. (Smeltzer et al. 2012, 831.) If the response to treatment is poor, it is recommended to use several different types of diuretics together. It is also important to emphasize the sodium and fluid restrictions when using diuretics. (Heikkilä et al. 2008, 758-759; Smeltzer et al. 2012, 832.)

The medication that decreases the neuroendocrine activity and alleviate the heart's workload includes ACE-inhibitors and ATR-blockers. They relieve the symptoms of heart failure and improve the prognosis of the disease. ACE-inhibitors and ATR-blocker have similar hemodynamic effects even though their mechanisms of action are different. (Heikkilä et al. 2008, 758; Smeltzer et al. 2012, 831.) Both of these medications inhibit specific hormones from functioning and therefore dilate veins and arteries and decrease the blood pressure (Heikkilä et al. 2008, 760). They also decrease the activation of sympathetic nervous system (Farmakologia ja toksikologia 2003).

Beta blockers decrease the symptoms that are caused by the stimulation of the sympathetic nervous system. They decrease pulse rate, the oxygen need of the heart, and diminish the sensitivity to arrhythmias. Beta blocker treatment is indicated in systolic heart failure. The symptoms of HF should be stable and other medication treatment already started before initiating beta blocker treatment. The treatment is started with small doses and regular monitoring of the clinical status is implemented. Heart failure can be also treated with combining other medication such as calcium channel blockers and digitalis. (Farmakologia ja toksikologia 2003; Heikkilä et al. 2008, 762-764; Smeltzer et al. 2012, 831.)

3.2.2 Fluid intake and weight monitoring

Heart failure patients' treatment requires them to monitor their intake of fluids closely due to the heart's decreased ability to circulate large volumes, which leads to fluid retention. The amount of fluids should be increased in special circumstances such as fever, hot weather or after heavy exercise. Fluid intake is a compound of drank fluids and the fluids contained by food. HF patient's fluids are usually restricted to 1500ml - 2000ml per day. The overall amount of fluids drank, contained in food, and the amount of salt digested all contribute to fluid retention. Recording fluid intake is essential when dealing with a strict fluid restriction. (Partanen 2011.)

Expert nurse Nyström (Nyström 2013) explained that patients may experience the fluid restriction to be hard to follow due to thirst, and sometimes patients even feel that the nurses are just harassing them by not giving them enough to drink. Giving the patient tips about how to ease the thirst in the form of ice cubes, saliva inducing mints, or dry mouth sprays helps the patient to cope (Nyström 2013).

Fluid retention in extremities cause swelling and discomfort for the patient. Fluid gathering to the lungs leads to dyspnea and dry cough. An upright position helps to ease dyspnea by reducing venous blood flow to the lungs. Fluids accumulating in the abdominal cavity can bring an unpleasant feeling of fullness, lead to a reduced nutrient intake by the body, and diminished appetite. Insufficient nutrition intake leads to actual weight loss, but the patient may seem to be gaining weight due to fluid accumulation. The

patient needs to monitor his/her weight in order to notice the fluid retention and therefore weight gaining. In HF, fluid retention can happen in a matter of hours or few days resulting to an increased workload for the heart, angina pectoris, dyspnea, and hospitalization. Recording the fluid intake and weight monitoring helps the patients to manage their disease. (Partanen & Lommi 2011.) To be able to measure fluid accumulation accurately, weight is monitored in the mornings before eating or drinking, after emptying the bladder, and using the same scale and clothing every time (Partanen 2011). Monitoring weight is essential for the patient to notice alarming fluid balance issues and to be able to contact health care professionals (Veroff, Sullivan, Shoptaw, Venator, Ochoa-Arvelo, Baxter, Manocchia & Wennberg 2012, 37).

3.2.3 Sodium-restricted diet

Part of a heart failure patient's treatment is a healthy diet with low sodium intake alongside the fluid restriction. Sodium binds fluids to itself, thus on-setting the symptoms. The human body needs only 0,5 grams of salt per day to function, an amount that is easily gained from food without adding salt while cooking or eating. The human body adapts gradually to a low salt diet. The recommended amount for HF patient is 5 grams, which equals a level teaspoon. (Partanen 2011.) However, a single cohort study made by Youn-Jung, Yongjik and Eun (2011) suggests an even stricter approach to restricting sodium. They found out that adhering to a sodium restricted diet where the salt consumption was less than three grams per day had positive effects on the HF patients. The patients that adhered to restricting sodium to three grams experienced less symptoms and they had longer cardiac event-free survival than patients not adhering to the diet. Even if other risk factors were being controlled, consuming over three grams of salt doubled the likelihood of a cardiac event, ER visits or death. (Youn-Jung et al. 2011, 3029, 3035.)

A study made by Lennie, Worrall-Carter, Hammash, Odom-Forren, Roser, Smith, Trupp, Chung & Moser (2007, 6-11) concerning HF patients' adherence and their perceived knowledge, barriers and attitudes, comprised a total of 246 patients from America and Australia. The patients had all been given guidance about following a low-sodium diet and they participated in the study by filling a three part questionnaire, and 145 of the patients also by giving a 24-hour urine sodium excretion sample. The study reveals the

health care educator's difficult task. Even though 80% of the patients remembered receiving low-sodium diet recommendations, they could not recall much of the recommendations. The study also hints at a memory and concentration problems that HF patients have stated as one possible reason behind the poor recall of the recommendations. Also 75% of those patients who said they followed the low-sodium diet most or all of the times had conflicting 24-hour urine sodium excretion levels, indicating that only 25% of the perceived 75% were adherent. The study concluded that even though patients think they have the know-how of following a low-sodium diet they might still inadvertently be consuming more sodium than they think they are. Most salt was consumed from processed foods without the patients realising it. Relentless reinforcement of education as well as ensuring and correcting what the patient has learned needs to be done by health care professionals to achieve better adherence. (Lennie et al. 2007, 6-11.)

Guiding the patient with HF to use spices and herbs instead of salt is beneficial (Sydämen vajaatoiminta: Käypä hoito-suositus, 2008). A healthy diet all in all is necessary in HF treatment and the diet should include vitamins and nutrients together with vegetables. Saturated fat should be replaced with unsaturated fat and quick release carbohydrates should be avoided. (Huttunen, 2012.) The Heart Symbol is a package label system that helps the patient to identify better products in terms of salt and fat amount (The Finnish Heart Association). The use of the Finnish plate model helps to fulfill the principles of a healthy diet. The plate model consists of filling half of the plate with vegetables or salads, one quarter with potato, rice or pasta, and the last quarter with meat or fish. Completed with a slice of whole wheat bread, a drink of water or fat free milk, and berries as dessert, the plate model represents the proportions of a healthy meal. (Valtion ravitsemusneuvottelukunta 2005.)

3.2.4 Living habits

Changing the living habits to healthier ones decreases the heart's workload, prevents the damage in the heart muscle from progressing, and intensifies the effect of the medication treatment. Smoking cessation is highly recommended, because smoking reduces the oxygen distribution to tissues and increases peripheral resistance. Abstinence from alcohol or minimum usage of alcohol is recommended, because it causes fluid

accumulation and electrolyte disturbances, as well as exposure to arrhythmias. Overweight increases the heart's workload, and therefore HF patients should be encouraged to lose weight. (Heikkilä et al. 2008, 756-757.) According to the Current Care Guidelines (Sydämen vajaatoiminta: Käypä hoito-suositus 2008), exercise is highly recommended for HF patients. Physical activity should be part of every-day life and it should be individually tailored. A suitable amount of exercise is approximately 30 minutes per day but even a small amount of physical activity is better than not exercising at all. (Sydämen vajaatoiminta: Käypä hoito-suositus 2008.) Heart failure does not prevent traveling, but it should be carefully planned ahead. Sitting in tight spaces for long periods of time increases the risk of deep vein thrombosis and swelling. (Penttilä 2011.) Fluid restriction and medication regimen should be followed also during travelling (Sydämen vajaatoiminta: Käypä hoito-suositus 2008).

Heart failure does not prevent patients from going to sauna. (Sydämen vajaatoiminta: Käypä hoito-suositus 2008). The heat dilates the blood vessels, decreases blood pressure and improves blood circulation. However, too hot sauna steams should be avoided. (Saunominen ja uiminen: Sydänliitto 2012.) According to Kihara, Biro, Imamura, Yoshifuku, Takasaki, Ikeda, Otuji, Minagoe, Toyama & Tei (2002, 754-759), a repeated 60 C° sauna treatment improved clinical symptoms of heart failure and improved the cardiac function amongst HF patients. In the study, twenty HF patients were treated in 60 C° sauna for 15 minutes following with a 30 minute bed rest. The experiment was implemented daily for two weeks. The study results indicate that 17 out of 20 HF patients had less clinical symptoms after the sauna therapy. (Kihara et al. 2002.)

3.2.5 Patient adherence

Patient adherence to HF management is the greatest challenge health care educators face (Turpin et al. 2004, 377). Limitations in judgment and knowledge as well as lack of belief in self-efficacy can be major negative components in patients' disease management. Even though giving information of the disease is vital, it does not guarantee patients' knowledge, because learning does not occur if the patient is unwilling to learn or is unaware of his/her lack of information. If the patient does not understand the benefits of dealing with the disease, he/she will make decisions that affect his/her condition negatively based on short term improvement of their quality of life. Patients have a right

to autonomy, but healthcare providers should make sure that the patient is making decisions based on evidence based data. Patients' self-care can be enhanced by simple improvements to patients' self-care methods, for example by introducing a pillbox to ease medication compliance. Positive experiences of self-care behavior should be provided by healthcare personnel to motivate the patients in their daily self-care. Support from health care providers as well as from significant others tends to motivate the patient's self-care. (Jaarsma, Abu-Saad, Dracup, & Halfens 2000, 117-118.)

4 PATIENT GUIDANCE

Guidance is one of the most essential jobs in nurses' and doctors' profession (Tuomi 2008, 51). Good patient guidance is a pertinent part of safe care. Parallel to guiding are motivating conversation, counselling, educating, and coaching. Guidance is often passing on the information to a patient. (Ahonen, Blek-Vehkaluoto, Ekola, Partamies, Sulosaari & Uski-Tallqvist 2012, 34.)

> Therapeutic education of patients is aimed both toward improving medical outcomes of chronic disease and enhancing patients' quality of life. Since changing attitudes and behaviour depends largely on psychological factors, personality, influence of surrounding people and society as a whole therapeutic education needs to take these factors into account. To achieve greater efficiency therapeutic education uses specific pedagogic methods based on principles of patient' empowerment, orientation on patient' needs and resources. (Petrov 2008, 51.)

A good quality patient guidance is based on principles which are useful for educating the patient. Most important issues have to be presented first, and they should be highlighted and repeated. Advice needs to be specific, exact and well categorized. Professional jargon should be avoided as well as long words and sentences. Audiovisual tools are beneficial. Advice should be patient-centred and realistic. Feedback is a good way to reassure that the message is understood. (Ewles & Simnett 1995, 183-184.) Tuomi (2008, 51) describes guidance as successful when the emphasis is on the patient's life and the patient has the final responsibility of changing his/her life. Specific needs of the target group should also be taken into consideration and the material tailored to cater their needs (Jaarsma et al. 2000, 117).

4.1 Guiding heart failure patients

The heart failure patient's guidance aims to improve the patient's quality of life, ease symptoms, prevent exacerbations, and reduce inevitable hospitalizations that occur because of neglecting treatment. A multidisciplinary approach to patients' care lowers the challenges that elderly patients are facing in their disease management. It is of crucial importance for the patient to understand the nature of heart failure to manage with it. The signs and symptoms of exacerbations need to be presented clearly to the patient, as well

as when the patient should contact health care professionals. (Naylor, Howe, Eggert & Heifferon 2004, 46-47, 49, 51.)

An article in Healthcare Benchmarks and Quality Improvement (2010, 137-138) tells about DMC Sinai-Grace hospital in Detroit that has managed to reduce readmission rates of HF by 30%. They achieved this by starting a transitional care model where they offered a high level of service and by improving the self-management skills of the patients. They found that finding the learner in the situation was paramount. The learner could also be the caregiver or a significant other, if the patient was not in charge of his/her treatment. The learner's learning level was assessed and a teach-back method applied by having the learner educate the instructor in the end of the teaching sessions. (Healthcare Benchmarks and Quality Improvement 2010, 137-138.)

According to Fradette, Bungard, Simpson, and Tsuyuki (2004, 387-388), HF patients' lack of understanding is an impediment to their disease management. Information concerning their condition and medication was received both in written and oral form, and early after the diagnosis it was perceived by the patients to be of highest value. To promote adherence, the provided information needs to be understandable, written in layman's terms, and easy to associate with patients' daily life activities. Health care professionals need to emphasize also the reasons behind the necessary lifestyle changes and how to achieve them through practical examples (Paul 2008, 74). The importance of effective lifestyle guidance in reducing the danger of combined heart and venous diseases is essential (Kohonnut verenpaine: Käypä hoito-suositus 2009).

4.2 DVD/Video as guiding material

Different learning styles are acknowledged to be helpful in education. Visual and auditory education methods deliver the message through different channels and allow people with different learning styles to adapt the information more successfully. Research shows that when comparing DVD with workbook, the DVD mode of delivery demonstrated superiority to the workbook. The DVD affected more effectively patients' perceptions, belief and knowledge in several important areas and the participants were more motivated. (Hill, McPhail, Hoffmann, Hill, Oliver, Beer, Brauer & Haines 2009, 1462.)

According to a randomized controlled study made by Veroff, Sullivan, Shoptaw, Venator, Ochoa-Arvelo, Baxter, Manocchia and Wennberg (2012, 41-42), patients' adherence was encouraged by video education in areas of self-care, following low sodium diet, monitoring fluid intake, and following their daily weight. The patients who received education through a video and a booklet were 44% more likely to weigh themselves daily than the control group who received education through a basic fact sheet only. The mode of education delivery through video is a relatively inexpensive way to reach large masses, has a wide distribution, and is an easy way for the patients to refer back to the key issues (Veroff et al. 2012, 41-42). A study made by Barnason, Zimmerman and Young (2011, 451) also has similar findings; in a setting where the intervention group received standard education coupled with a video education session during their hospitalization, it was discovered that the group's self-care behaviour was significantly higher when measured after 90 days.

5 THE PROCESS OF THE BACHELOR'S THESIS

In this section of the Bachelor's thesis, the methodology used is discussed, and the process of making a guidance video is presented in a chronological order. The process, what was done, and why and how it was done are examined (Vilkka & Airaksinen, 2003, 65).

5.1 Functional thesis

A functional thesis is an alternative to theoretical and empirical theses that focus on describing the process of combining the professional theoretical framework and practice. The aim of a functional thesis is to create a product that either educates, guides, organizes, or rationalizes the professional practice. The end product can for example be a guide or an instruction as a booklet or a cd-rom. It can also be an implementation of an event, such as an exhibition, a guiding session, or a conference. (Vilkka & Airaksinen 2003, 9, 52.) The aim of a functional thesis is to show the student's ability to combine theoretical knowledge of a paradigm with practice, to show the student's ability to critically evaluate practice through theories, and to demonstrate the readiness to promote the profession through them (Vilkka & Airaksinen 2003, 41-42).

In a functional thesis, the guide, instruction or exhibition is always targeted for someone or for someone's usage. Establishing the target group is crucial, because it determines the content of the production and helps the producers to choose target specific content. (Vilkka & Airaksinen 2003, 38, 42).

The theoretical framework can be gathered using the key concepts. The theory gathered should be critically evaluated and chosen to suit the end product. (Vilkka & Airaksinen 2003, 43, 53.) Vilkka and Airaksinen (2003, 58) elaborate that gathering information and clarifying facts through an expert interview adds the credibility of the thesis' theoretical part. Polit and Beck (2008, 481) describe an expert as a person who knows the target population and key construct of the subject.

A functional thesis consists of two parts which are the report and the product. The report part concentrates on the description of the process and the student's learning outcomes,

while the product part focuses on passing on the information of the topic for the target group. (Vilkka & Airaksinen 2003, 65.)

5.2 The beginning of the process

The topic of this Bachelor's thesis was chosen from the Bachelor's thesis topic presentation seminar organised by the Tampere University of Applied Sciences in August 2012. Cardiac ward B5 from Hatanpää Hospital had requested a patient guidance DVD about heart failure to be made. We chose this topic, since we saw it as a useful way to educate ourselves deeper about a subject that was interesting, and we were also drawn to the fact that the end product would benefit the nursing community as a guidance tool. Later in the process of making the thesis, the end product as a DVD changed to a more modern form as a video. The guidance video will be available in Hatanpää Hospital's website.

Ward B5 is an internal medicine ward specialized in cardiology. The major patient groups in the ward are heart failure, arrhythmia, and angina pectoris patients, as well as patients undergoing blood pressure examinations. (Tampereen kaupunki 2012.) We were commissioned to produce a guidance video for the newly diagnosed patients with heart failure to replace their outdated guidance video. In working life, successful patient guidance is one of the cornerstones of nursing, and education material available via different learning channels enhances the patient's learning and facilitates better self-care. Our guidance video is meant to be shown in a setting where the nurse is present with the patient and is available to answer the questions the patient has after viewing the video, in order to deepen the patient's learning. The video can be used by patients also as a reminder of the important aspects in managing heart failure.

After choosing the subject for the Bachelor's thesis, we had a meeting with the working life connection in September 2012 to hear their ideas and requirements for the video. We suggested that the video would be spoken in Finnish but subtitled in English and possibly signed in Finnish Sign Language to make it more available for a larger number of patients. Later in the process, it was discovered that the video could not be provided in Finnish Sign Language, since the work has to be offered to the Sign Language interpreter school

as a Bachelor's thesis commission. In addition, we ended up leaving the subtitles out due to the time constraint and technical difficulties.

In the meeting, we determined the frames for the guidance video and the ward manager of B5 presented his vision of the video; the target group of the video are patients with newly diagnosed heart failure and their significant others. The video is to be used as a guiding tool for cardiac nurses when educating the patients about their heart failure. The maximum length of the video should be ten minutes. The style of the video should be simple and in layman's terms. The video should be in accordance with the Current Care Guidelines. Topics that were particularly requested to be included in the video were sauna, adherence to medication regimen, and concrete examples of healthy choices.

5.3 Journey through the process

5.3.1 Theory framework

The suggestions of the working life partner for the content guided the process of narrowing down the contents of the video and allowed us to determine the theoretical framework. To the framework that is presented in sections three and four of the thesis, the theory used to create the guidance video has been assembled. The theory was gathered by conducting a literature review made through CINAHL, Duodecim and books provided by Tampere University of Applied Sciences' library. The articles and studies used were published between the years 1995-2013. Through the literature review, information concerning the three key concepts was found:

1. Heart failure
2. Efficient patient guidance
3. DVD/Video as a guiding tool

As the theoretical framework became clear to us, we wrote a Bachelor's thesis plan to guide the process. The plan included a timetable that helped us to visualize the work and the next steps ahead. However, the timetable had to be revised many times due to the manuscript taking us longer to do than we had evaluated. Also the final practical trainings

made it challenging for us to find suitable time together to make the thesis. The original timetable was modified many times during the course of the work. The Bachelor's thesis plan was completed in January 2013 and it was also sent to Hatanpää Hospital for approval. The research permission was approved in February 2013. Along the process of making the Bachelor's thesis, we held a thesis diary to document the different phases of the process, as well as a video diary to document the video shoot days. The thesis diary consisted of a notebook where the date and the occurred progress of the process were written. The diaries offered great support to us when writing the report.

The aim for the video was to portrait the necessary life changes, symptoms and guidelines in an easy, positive, compact and visual way. In addition to the literature review, we watched ten diverse guiding DVDs to discern how to make a good quality guidance video. The videos were evaluated from the technical and educational points of view. Technically successful videos were those that included a clear narrator's voice, scenes that lasted long enough, and where editing was successful and the order of scenes was logical. As for the videos where the editing was not successful, the video lasted too long and failed to capture the audience, colors were odd, or the voice was not clear, made conveying the message to the viewer more difficult.

From the educational point of view, we noticed that the videos most successful in conveying the intended message were those which had clear instructions, pictures to illustrate the main points, important information repeated, a professional attitude, and which were positive, realistic and made from the patient's point of view. Disruptive factors were too fast a pace, use of professional jargon, and incohesive scenes. These findings were consistent with the background theory we had gathered. Keeping in mind the theory of efficient patient education, we planned the style and content of the video to maximize the patient's chance of understanding and remembering the offered information. We hoped to achieve a video that was visually clear, informative, that repeated the main points without professional jargon, was made from the patient's point of view, and had an empowering attitude.

In the end of March 2013, an expert interview was conducted that gave valuable insight to the difficulties of a heart failure patient to manage her/his disease and to what areas to highlight in the guidance video. We interviewed cardiac nurse Susanna Nyström from

ward B5, who also offers phone consultation hours to HF patients with questions concerning their condition. According to Nyström (2013), the most troubling areas in the patient's self-care are their lack of understanding on the importance of taking their medication regularly, keeping the fluid balance, and how the relation of beneficial life changes to their symptom management affects their disease and prevents the exacerbations of HF. She emphasized the fact that the treatment should continue at home after discharge from the hospital. The patients also need clear and factual information about the disease itself in order to take care of themselves. (Nyström, 2013.)

5.3.2 Making the manuscript

From the process point of view, making the manuscript (appendix 1) was the most time consuming part. Some of the video content was suggested by the working life connection, like going to sauna. They wanted sauna included because it is a crucial aspect of Finnish life. This posed a problem, since we were unable to find theory to support the sauna going for heart failure patients. Sauna going was added still to the manuscript, because it is a frequently asked question by HF patients (Nyström 2013). Later on in the process, we were surprised to find articles that supported HF patient's sauna going.

The topic heart failure is a vast subject and we were dealing with a time constraint of ten minutes maximum on the guidance video. Besides trying to include the most important information about treating heart failure, it was found out that in order for the message to be received, there should be a slow enough pace with reiteration packed in a visually interesting wrapper. We aimed for an atmosphere where the patient would feel empowered, receive information about his/her disease, and know what to do in case the condition was exacerbated. Keeping in mind the target group, the video was also aimed to be audio visually clear and without distractions from the main message. The manuscript was a co-joint effort, but one of us was assigned to be in charge of the visual way of delivering the message, while the other focused on delivering the message via the narrator's text. The duality of the work can still be seen in the manuscript's framing, the narrator's part and the scene plan being divided into separate columns.

The creation of the manuscript (appendix 1) started in February 2013 and its honing lasted until the video shootings started in August 2013. Along the process of writing the manuscript, feedback was asked from our working life connection repeatedly, and changes were made according to it. The final approval from the ward manager for the finished manuscript was received in August 2013, and the shooting of the video begun right after that.

5.3.3 Filming

The biggest question that aroused right at the beginning of the commission was the video shooting equipment. We were hoping to find co-workers from other education lines from TAMK to help film and edit the video, leaving us in charge of our own area of expertise; the content of the video and patient guidance. Unfortunately, due to time constraints, we were unable to find such co-workers. However, the entrepreneurship community in Tampere University of Applied Sciences (TAMK) offered help by loaning an iPad to shoot the video with, and to help to use the program in which to edit the video. After careful consideration, we came to a conclusion that filming with an iPad would have been challenging from a technical point of view and we were hesitant of the quality reached with iPad. Thus, we resorted to shoot and edit the video by ourselves and to find the equipment for it by ourselves.

All the acting, recording the narrator's voice, and editing was done pro bono by volunteers. There were two actors, a narrator, a sound recorder, and an editor partaking in the production of the video. The leading character, a patient with a heart failure, was played by a retired man who was thought to present a realistic feature in the story. The actor for the nurse's character was a 22-year-old nursing student who had an acting background in the amateur theatre. The narrator was from our class and chosen because of the tone and clarity of her voice, and the clearness of pronunciation. We signed copyright contracts (appendix 2) with the actors and the narrator. The contract included the agreement of participating voluntarily on the video and relinquishing the rights of the use of the shot material to us. Filming and directing was done solely by us.

The video shoots were conducted in TAMK premises and public places in Tampere scouted beforehand. We made a set in TAMK facilities for the nurse's consulting room and the scenes where the patient is at home. Also the footage concerning walking up the stairs by the patient was located in TAMK. The outdoor shooting took place in a public park in Hatanpää, which was chosen because of its verdant view. Since neither of us had any experience of shooting a video, we were challenged with technical difficulties concerning the small spaces allocated to us, proper angles of the camera and capturing good quality sound without distractions. These problems led to some re-shootings that were unplanned for. All in all, the video shooting took three days in total.

5.3.4 Voice recording and editing

The voice recording of the narrator was done by a volunteer who had the needed equipment for recording and editing the soundtrack. We were in charge of directing the voice actor. The effect of the narrator's voice we hoped to achieve on the guiding video was upbeat, calm, clear, and not preaching. The recording was completed without any difficulties in 4 hours.

We edited the footage together with help from another volunteer who had previous experience in editing. While editing, we noticed that we had less usable footage than what was needed for the scenes. Therefore, we had to react by changing some of the planned visual aspects and by shooting some more footage. It was also planned to use texts that would appear on the screen in accordance with the narrator's voice, but due to the editing program's settings, this kind of feature was not possible. Despite minor changes, we feel that all in all the editing of the video went according to the plans and the outcome was more than we hoped to achieve. All in all, the editing took approximately 24 hours in total, which was a surprisingly long time and more than we had planned for.

5.4 Final steps of the process

Writing the thesis report was finished in October. The guidance video was sent to ward B5 in October 2013 for evaluation, feedback and suggestions for minor changes. We

revised the video according to the feedback and handed over the finished guidance video in October 2013. The thesis was completed in October 2013 after being evaluated by the mentor teacher, the English teacher, and working life. At the end of November, the thesis was presented in TAMK Research Day.

6 DISCUSSION

6.1 Trustworthiness

Our Bachelor's thesis is a functional thesis with a product, and we have not conducted a study per se. Moreover, our thesis consists of obtaining the theory and defining the educational needs of HF patients with an expert interview in accordance with the scientific research rules. The ethical issues in the thesis concern the copyright regulations and conducting a thesis following nursing research ethics. According to a US Public Health Service regulation (42 CFR Part 93), research misconduct can occur as a fabrication, falsification or plagiarism of any data during the phases of the study (Polit & Beck 2012, 168-169). During obtaining the theoretical knowledge, we have strived to find the most recent, valid and reviewed articles and studies to uphold the ethics of scientific reporting. By marking the references accurately, we have increased the credibility of our Bachelor's thesis. We have also presented the theory staying true to the source material, without plagiarism or falsification of study results. (Polit & Beck 2012, 174-175.) The expert interview we conducted supports the theory we obtained and increases the validity of this thesis.

In the research application, we explained that no actual patients would be filmed on the guidance video and the research permission was granted to us by Hatanpää Hospital. According to Polit and Beck (2012, 157), through an informed consent the researcher explains the study to the participant and the participant after understanding the content of the study has the possibility to accept or to decline voluntarily. Our actors and narrator all agreed to participate in this project voluntarily and they signed an informed consent form during the process. In the consent form, we promised to use the obtained material only for the purposes of making this product and thesis projects. The material used in the product follows the copyright rules. Pictures and video material were taken by us to avoid violating the copyright law (Tekijänoikeuslaki 1961/404). The music in the background was taken from a free website that offers copyright free compositions. The video is spoken in Finnish, limiting the availability to Finnish speaking population.

6.2 Evaluation of the thesis

The process of writing the Bachelor's thesis went consistently. We started by defining the subject and made sure both had a clear picture of the whole process. The background theory was gathered separately and analyzed together. The relevant theoretical information was easy to find, since there are many studies conducted concerning heart failure and patient education. We started to write the theory section together, but soon realized that it was not productive. Also practical training periods and summer jobs restricted our time together, and we settled on writing partly individually. Google Drive was a great help, allowing to be in different parts of Finland and still work on the thesis simultaneously. Our writings were accepted and corrected by each other. Apart from obtaining the theory, this thesis has been made together. This thesis was written following Virikko's (2012) report guidelines for TAMK (Kirjallisen raportoinnin ohje 2012).

The thesis subject was chosen to be able to deepen our knowledge about patient education, heart failure, and making an educational product. Vilkka & Airaksinen (2003, 24) support this approach and also make a point that a topic should not be discarded simply because it contains fields that you have no previous education in. We were encouraged by these words, and in the beginning of making the product we evaluated our strengths and weaknesses through a SWOT analysis. We realized that due to our professional education to become nurses, our strengths lie in making the manuscript. Filming and editing were the weaknesses, and this troubled us. Nevertheless, we saw this topic as an opportunity to learn more about filming, editing, patient guidance, and making a functional thesis. The biggest threat that was feared was that the video would fail to deliver the intended message, not because of the content but because of our inability to master filming and editing.

Our plan for making the product had a clear order; make the manuscript, shoot the video, and edit it. In hindsight, this proved to be too naive an approach, because the reality was a constant flux between the three. Outlining the manuscript was challenging, but we feel that the work division was successful and we were happy with the content we managed to include in the video. Phrasing the narrator's text also was difficult, since preaching was to be avoided and the aim was to provide an empowering experience for the patient.

Directing the actors to convey the desired tone on the video was challenging, and finding the correct tone took many shootings. In the shooting and editing phase, we realized problems that we did not expect in the manuscript working phase. Problems arose especially concerning the visual side and shooting; our footage not lasting long enough for the narrator's tale, a force majeure situation when dealing with nature, keeping the camera steady, or a hand showing persistently in the shot material. Additionally, while filming the video the work distribution should have been clearer. Clear allocations of directing and responsibility of handling the camera would have clarified the video shoots.

Editing exposed a vulnerability in our plans, which was that we had not looked into the attributes of the editing program closely enough before setting objectives for the video. Without a volunteer editor helping us, we would have been left with a far inferior product. For future reference, when making a video, an experienced editor is an important asset.

Evaluating the finished product objectively was difficult. However, we evaluated the product to be relevant, positive, with clear content and enough repetition to enforce the message. Also the scenery in the video was successful, and we were especially grateful of the narrator choice. We also would have liked to include animations to highlight the message, but that would have taken more time to learn than we had resources. We are happy with the fact that we have a patient in the video visualizing the different aspects of self-management of the condition. All in all, we believe the guidance video to be useful in patient guidance of patients with HF.

After returning the video for approval feedback from the working life connection was received stating that the video was a positive surprise, the inclusion of Hatanpää sceneries was good, the patient looked authentic, the content consisted of facts, and the video was executed like agreed. In addition, he felt that the video's ending line of the patient speaking about his ability to manage the condition positively was a good ending. In the feedback, there were also some suggestions on changing the color scheme to follow ward B5's colors and of adding the logo HHH - Hyvän Hoidon Hatanpää to the video. The logo was added, but we decided to keep the original color plan because the logo had the same coloring as the suggested new color, which would have made the logo unnoticeable. Writing the thesis report was finished in October, the main focus of the writing being on

the end of the process, which is characteristic of a functional thesis due to its nature as a description of the process.

6.3 Further study suggestions

Our suggestion for future Bachelor's theses is a multitude of educational videos dividing the topic into smaller proportions to benefit the patient who knows what area of information he/she is lacking. Quizzes or games for a heart failure patient to test his/her knowledge and to educate him/her about heart failure would give valuable insight on their knowledge level, and a questionnaire delivered to HF patients would give information on how well the video answers their needs.

7 CONCLUSION

Our aim was to produce a clear and informative guidance video for patients with newly diagnosed heart failure. Efficient patient guidance and patients' self-care are essential in managing heart failure. Lack of information or misconceptions are hindrances in heart failure treatment. According to the established theory, audiovisual education material combined with an individual guiding setting improves the patient's learning outcomes. We feel that our guidance video is beneficial, clear, informative, and made using layman's terms, thus promoting the HF patient's self-care and disease management.

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APPENDICES

Appendix 1. Manuscript

SYDÄMEN VAJAATOIMINTA OHJAUSVIDEO POTILAALLE	Taustamusiikki alkaa.
KOHTAUS 1 Taudin esittely - Osa 1 Kuvauspaikka: Puisto, Tampere Henkilöt: Potilas Viljo kävelee puistokatua pitkin aurinkoisena päivänä, istahtaa puistonpenkille.	Kertoja: ”Sydämen vajaatoiminta on pysyvä pitkäaikainen sairaus, jonka hoitoon kuuluu lääkitys ja elämäntapamuutokset. Vajaatoiminta voi johtua monista eri sydän- ja verisuonitaudeista, kuten sepelvaltimotauti, verenpainetauti ja läppäviat. Harvinaisempiin syihin lukeutuvat sydänlihassairaudet ja rytmihäiriöt. ”
SYDÄMEN VAJAATOIMINNAN OIREET valkoinen teksti sinisellä taustalla	
KOHTAUS 2 Taudin esittely - Osa 2 Taustakuva: potilas kävelee puistossa sekä seisoo laiturilla nojaten kaiteeseen. Informatiivinen tekstilaatikko. Otsikko: Oireet Teksti: - Hengenahdistus -Painonnousu -Turvotus -Lihasten voimattomuus -Väsymys -Ruokahaluttomuus -Yskä	Kertoja: ”Sydämen vajaatoiminnassa sydämen kyky pumpata verta verenkiertoon on heikentynyt. Tämä aiheuttaa erilaisia oireita, jotka ilmenevät hengenahdistuksena, painonnousuna, turvotuksina, lihasten voimattomuutena, väsymyksenä, ruokahaluttomuutena ja kuivana yskänä yöaikaan. ”
KOHTAUS 3 Oireet - Osa 1 Kuvauspaikka: Portaikko sisätiloissa, TAMK Henkilöt: Potilas Potilas kävelee portaita sisätiloissa. Kesken portaiden pysähtyy, menee etukumaraan, ottaa kaiteesta kiinni ja laittaa toisen käden polvelle. Hengittää raskaan oloisesti. Jatkaa kävelyään.	Kertoja: ”Yksi vajaatoiminnan oireista on hengenahdistus. Hengenahdistusta voi esiintyä rasituksessa, levossa sekä maaten. Myös lihakset voivat tuntua voimattomilta. Tämä liittyy sydämen heikentyneeseen kykyyn pumpata verta elimistöön ja lihaksiin. ” Taustamusiikki päättyy.

KOHTAUS 4 Oireet - Osa 2 Kuvauspaikka: TAMK, sairaanhoitajan vastaanotto -lavastus Henkilöt: Sairaanhoitaja ja Potilas Potilas saapuu vastaanottohuoneeseen, istuu penkille ja kättelee sairaanhoitajaa. *Sairaanhoitajan vuorosanat.* Potilas istuu sairaanhoitajan vastaanoton tuolilla ja nostaa housun lahkeet ylös. Sairaanhoitaja tarkastelee nilkkoja ja sääriä. Taustalla kertojan ääni.	Sairaanhoitaja: ”Hei, sairaanhoitaja Oinonen. Joo katsotaan vaan niitä jalkoja.” Kertoja: ”Painon nousu lyhyessä ajassa kertoo nesteen kertymisestä elimistöön, mikä esiintyy yleisimmin hengenahdistuksena ja turvotuksina nilkoissa sekä säärissä. Oireisiin voi kuulua myös poikkeava väsymys ja huono ruokahalu. Kuivaa yskää esiintyy makuuasennossa, mikä puolestaan häiritsee yöunia.”
SYDÄMEN VAJAATOIMINNAN HOITO - valkoinen teksti sinisellä taustalla	
KOHTAUS 5 Hoidon esittely Taustakuva: Sairaanhoitaja esittelee sydänmallia potilaalle vastaanotollaan. Informatiivinen tekstilaatikko: -Lääkkeet -Paino -Nesterajoitus -Ruokavalio -Liikunta -Motivaatio	Kertoja: ”Sydämen vajaatoimintaa hoidetaan lääkkeillä, seuraamalla painoa, nesterajoituksella, oikealla ruokavaliolla ja liikunnalla. Voit itse vaikuttaa vointiisi. Osallistumisesi hoitoon parantaa taudin ennustetta.”
KOHTAUS 6 Hoito – Ravitsemus 1 Kuvauspaikka: TAMK, sairaanhoitajan vastaanotto -lavastus Henkilöt: Potilas ja sairaanhoitaja Potilas istuu vastaanotolla, sairaanhoitaja esittelee terveellisiä ruokavaihtoehtoja esitteestä.	Kertoja: ”Terveellinen ruokavalio on yksi hoidon kulmakivistä. Suosi vähäsuolaisia ja vähärasvaisia tuotteita sekä nauti paljon kasviksia ja kuituja. ”

KOHTAUS 7 Hoito – Ravitsemus 2 Kuvauspaikka: TAMK, sairaanhoitajan vastaanotto -lavastus Henkilöt: Potilas ja sairaanhoitaja Potilas istuu vastaanotolla, sairaanhoitaja ohjeistaa terveellisestä ruokavaliosta. Pöydällä lautasmallikuva.	Sairaanhoitaja: ”Suolan käyttöä kannattaa välttää, koska se kerää nestettä elimistöön ja lisää janon tunnettasi. Suolan sijaan voi käyttää mausteita. Voi kannattaa vaihtaa rypsiöljyyn. Kaupasta löydät sydänmerkillä varustettuja tuotteita, jotka ovat sydänystävällisiä. Kannattaa noudattaa lautasmallia, jolloin puolet lautasesta täytetään kasviksilla, neljännes perunalla, riisillä tai pastalla ja viimeinen neljännes vähärasvaisella lihalla. Lisäksi voit syödä täysjyväleivän ja nauttia lasin maitoa”
KOHTAUS 8 Hoito – Nestetasapaino 1 Kuvauspaikka: TAMK, koti -lavastus Henkilöt: Potilas Potilas astuu vaa’alle kotonaan aamutakissaan ja kirjoittaa painon ylös vihkoon joka on keittiön pöydällä. **Lähikuva:** Kirjoittaa kynällä painon vihkoon, sana ”Paino” näkyy kuvassa.	Kertoja: ”Nestetasapainon tarkkailu on olennainen osa vajaatoiminnan hoitoa. Nesteen kertymistä seurataan mittaamalla paino päivittäin. Paino mitataan aamuisin wc-käynnin jälkeen aina samalla vaa’alla ja samoilla vaatteilla. Jos paino on noussut nopeasti, se voi olla seurausta liiallisesta nesteiden nauttimisesta tai siitä että lääkkeet ovat jääneet ottamatta.”
KOHTAUS 9 Hoito – Nestetasapaino 2 Kuvauspaikka: TAMK, koti -lavastus Henkilöt: Potilas Potilas juo keittiön pöydän ääressä lasillisen vettä. Pöydällä on vihko. Potilas ottaa kynän käteen ja alkaa kirjoittamaan. **Lähikuva:** Kynällä kirjoittaa 1dl vihkossa olevaan nestelistaan. Sana ”nestelista” näkyy lähikuvassa.	Kertoja: ”Nesterajoitus on yleensä noin 2 litraa vuorokaudessa, ja sitä on tärkeää noudattaa turvotuksien ja hengenahdistuksen ehkäisemiseksi. Nautittujen nesteiden määrää on helppo seurata pitämällä nestelistaa. Helteisenä päivänä, kuumeessa ja ripulissa nesteiden tarve lisääntyy, jolloin voit kohtuudella lisätä nesteen määrää. Janon tunnetta voit helpottaa esimerkiksi imeskelemällä jääpaloja tai pastilleja. Apteekista on saatavana myös kosteuttavaa suusuihketta. ”

KOHTAUS 10 Hoito – Lääkkeet 1 Lähikuva, jossa lasi vettä, valkoinen lääkepurkki ja pöydällä kaksi tablettia.	Kertoja: ”Sydämen vajaatoiminnan lääkehoidon tarkoituksena on vaikuttaa taudin perussyyhyn ja lievittää oireita. ”
KOHTAUS 11 Hoito – Lääkkeet 2 Kuvauspaikka: TAMK, koti -lavastus Henkilöt: Potilas Potilas istuu keittiön pöydän ääressä. Ottaa dosetistaan lääkkeitä, laittaa suuhun ja juo lasista vettä. **Lähikuva:** Potilas pitelee kiinni dosetista. Kuvassa teksti: ”Noudata hoito-ohjeta Ota lääkkeet säännöllisesti” Lopuksi potilas sanoo vuorosanat.	Kertoja: ”Vajaatoimintaa hoidetaan sydänlääkkeillä ja nesteenpoistolääkkeillä. Nesteenpoistolääkkeet, eli diureetit, auttavat poistamaan elimistöön kertyvää ylimääräistä nestettä, joka puolestaan ehkäisee turvotuksia ja hengenahdistusta. Diureettien avulla sydämeen palaava verimäärä vähenee jolloin sydämen kuormitus pienenee. Nesteenpoistolääkkeet otetaan päiväaikaan jotta lisääntynyt virtsaamistarve ei häiritse yöunia. Sydänlääkkeet, kuten beetasalpaajat, ATR-salpaajat ja ACE-estäjät alentavat verenpainetta ja parantavat sydämen suorituskykyä. Sydämen vajaatoiminnan hoidon kannalta on tärkeää, että noudatat saatuja hoito-ohjeita ja lääkemääräyksiä. Lääkärin määräämät lääkkeet tulee ottaa säännöllisesti jotta vältytään oireiden pahenemiselta. Sairaalassa aloitetun hoidon tulee jatkua myös kotona.” Potilas: ”Dosetista tulee otettua lääkkeet oikeaan aikaan. Kyllä sen olossaan huomaa, jos on jättänyt lääkkeet ottamatta.”
KOHTAUS 12 Hoito- Elämäntavat Lähikuva alkoholipullosta sekä kahdesta tupakasta.	Kertoja: ”Sydämen vajaatoimintaa pahentaa tupakointi ja runsas alkoholin käyttö, joten niitä tulisi välttää.”

KOHTAUS 12 Hoito- Elämäntavat Kuvauspaikka: Puisto, Tampere Henkilöt: Potilas Potilas sauvakävelee puistossa	Kertoja: ”Päivittäinen kestävyysliikunta puolestaan parantaa sydämen toimintaa, fyysistä suorituskykyä ja elimistön verenkiertoa. Kannattaa aloittaa liikunta vähitellen ja tehdä pieniä kävelylenkkejä kerrallaan. Sydämen vajaatoiminta ei estä saunomista. Saunominen kuitenkin lisää janon tunnetta ja hikoilua, joten liian pitkiä löylyjä tulisi välttää. Nesterajoitus kannattaa pitää mielessä myös saunan jälkeen. Matkustamiseen kannattaa varautua ajoissa. Pitkään ja ahtaasti istuminen lisää turvotuksia ja laskimotukoksen riskiä. Mahdollisuuksien mukaan on hyvä nousta jaloittelemaan. Lääkäriin on hyvä ottaa yhteyttä jos matkustetaan ulkomaille kuumaan ilmastoon. Myös lääkitystä ja nesterajoitusta on syytä noudattaa matkan aikana.”
SYDÄMEN VAJAATOIMINNAN PAHENTUMINEN – valkoinen teksti sinisellä taustalla	
KOHTAUS 13 Pahenemisvaihe Informatiivinen tekstilaatikko. Valkoinen teksti sinisellä taustalla Otsikko: PAHENEMISOIREET - Hengenahdistus - Väsymys - Turvotus - Painonnousu - Kuiva yskä - Sydänoireet - Verenpaineen nousu - Ruokahaluttomuus - Tulehdussairaudet	Kertoja: ”Sydämen vajaatoiminnan pahentuminen voi esiintyä lisääntyneenä hengenahdistuksena pienessäkin rasituksessa, levolla tai makuulla ollessa. Voi ilmaantua väsymystä tai lihasten voimattomuutta, turvotuksia nilkoissa tai säärissä, sekä nopeaa painon nousua. Oireina voi myös olla yöllinen kuiva yskä, erilaiset sydänoireet kuten rytmihäiriöt tai sydämen sykkeen muutokset. Myös verenpaineen nousua, huimausta sekä ruokahaluttomuutta voi esiintyä. Pitkittyneet tulehdussairaudet voivat pahentaa sydämen vajaatoimintaa, miksi on tärkeää ottaa ajoissa yhteyttä omaan terveydenhuoltoon.”

ITSEHOITO - valkoinen teksti sinisellä taustalla	
KOHTAUS 14 Itsehoito Informatiivinen tekstilaatikko. Valkoinen teksti sinisellä taustalla. Otsikko: Itsehoito - Seuraa vointiasi - Noudata lääkehoitoa - Seuraa nestetasapaino - Tarkkaile painoa säännöllisesti	Kertoja: ”Sydämen vajaatoiminta on etenevä sairaus. Jokainen pahenemisvaihe huonontaa ennustetta. Siksi on tärkeää että hoidat itseäsi ja seuraat vointiasi huolellisesti. On tärkeää, että noudatat lääkehoitoa ja nesterajoitusta, tarkkailet painoasi sekä merkkejä pahenemisvaiheen oireista. Ottamalla ajoissa yhteyttä hoitoon voit ehkäistä sairaalaan joutumista ja nopeuttaa toipumista.”
KOHTAUS 15 - Yhteystiedot Taustakuva: kuva Hatanpään Sairaalasta Teksti: HATANPÄÄN SAIRAALA, osasto B5 sydänhoitaja 03-56573369	Kertoja: ”Mikäli huomaat muutosta voinnissasi tai sinulla on kysyttävää, ota yhteyttä Hatanpään Sairaalan osasto B5:n sydänhoitajaan. 03-56573369 ”
KOHTAUS 16 Kuvauspaikka: Puisto, Tampere Henkilöt: Potilas Lähikuva potilaasta puistossa, vuorosanat	Potilas: ”Olen itse aktiivinen hoidossani. Otan lääkkeet säännöllisesti, syön terveellisesti, seuraan nestemäärää mitä juon ja mittaan painoa. Jos mun voinnissa tuntuu olevan muutosta niin tiedän ottaa yhteyttä sydänhoitajaan. Voin itse vaikuttaa omaan hyvinvointiini”
Ohjausvideo sydämen vajaatoiminnasta Tekijät: Milla Moilanen ja Kaisa Vuorinen Näyttelijät: Kertojan ääni Salla Löf Potilas Kalevi Kaikkonen Sairaanhoitaja Noora Oinonen Kiitokset: Hatanpään sairaala osasto B5 Tampereen Ammattikorkeakoulu	Taustamusiikki.

Appendix 2. Kuvaussopimus

Pyydämme Teitä osallistumaan opinnäytetyöhömme video-osuuteen näyttelijänä/ääninäyttelijänä. Opinnäytetyön tarkoituksena on tarjota ohjausvideo sydämen vajaatoiminta potilaille.

Osallistumisenne tähän opinnäytetyöhön on täysin vapaaehtoista ilman palkkiota. Opinnäytetyölle on myönnetty lupa Hatanpään sairaalalta, joka toimii opinnäytetyön yhteistyötahona.

Opinnäytetyö toteutetaan kuvaamalla materiaalia potilaanohjaus videoon ja nauhoittamalla ääninäyttelijän ääniraita. Video editoidaan ja luovutetaan Hatanpään sairaalan osaston B5 käyttöön ohjausmateriaaliksi osaston nettisivuille. Opinnäytetyöhön kuuluu myös kirjallinen osio, jossa esitellään teoriaa ohjausvideon sisällöstä sekä selvitys prosessin kulusta.

Teiltä pyydetään kirjallinen suostumus opinnäytetyöhön osallistumisesta. Opinnäytetyöt ovat luettavissa elektronisessa Theseus -tietokannassa, ellei Hatanpään sairaalan kanssa ole muuta sovittu.

Mikäli Teillä on kysyttävää tai haluatte lisätietoja opinnäytetyöstämme, vastaamme mielellämme.

Milla Moilanen
Sairaanhoitajaopiskelija (AMK)
Tampereen ammattikorkeakoulu
milla.moilanen@health.tamk.fi

Kaisa Vuorinen
Sairaanhoitajaopiskelija (AMK)
Tampereen ammattikorkeakoulu
kaisa.virtanen@health.tamk.fi

Kuvaus/äänitys sopimus

Tällä sopimuksella sovitaan videokuvien, ääniraitojen ja prosessin yhteydestä otettujen valokuvien käytöstä. Kuvauksista/äänityksestä ei makseta kuvaajille tai kuvattavalle/äänitettävälle rahallista korvausta. Tämän sopimuksen allekirjoittamalla kuvattava/äänitettävä kertoo ymmärtävänsä että kuvauksissa/äänityksessä saatua materiaalia käytetään julkisessa mediassa ja luopuu kaikista oikeuksista videokuvaan/ääniraitaan jota käytetään hyvän maun ja Suomen lakien mukaisesti osana kuvaajien lopputyötä Tampereen Ammattikorkeakoulussa.

Kuvaajilla on oikeus julkaista valokuvia, ääniraitoja sekä videokuvaa tai niiden muunnoksia portfoliossa, posterissa, Hatanpään sairaalan sivuilla sekä kaikissa luvallisissa medioissa mukaan lukien sähköiset mediat kuten internet sivut, multimedia ja video, ilman alueellisia rajoituksia. Kuvien, ääniraitojen tai videon muu kaupallinen käyttö on kielletty ilman kuvaajien ja kuvattavan tai äänitettävän yhteistä suostumusta. Lähtökohtaisesti kuvaajat omistavat valokuvien, ääniraitojen ja videokuvien kaikki tekijänoikeudet.

Kuvaaja

_____

Allekirjoitus ja nimenselvennös

Kuvaaja

_____

Allekirjoitus ja nimenselvennös

Kuvattava/äänitettävä

_____

Allekirjoitus ja nimenselvennös

Aika ja paikka