

# CARING FOR A PATIENT WITH RHEUMATOID ARTHRITIS DURING THE EXACERBATION PHASE OF THE DISEASE

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## Abstract

**Introduction:** Rheumatoid arthritis (RA) is a chronic, inflammatory autoimmune disease characterized by pain, swelling, morning stiffness and progressive loss of joint function due to deformation. Caring for a patient with RA requires an interdisciplinary approach that includes doctors, nurses, physiotherapists, psychologists and social workers, as well as the patient's family/legal guardians.

**Aim of the study:** to identify care and therapeutic problems in a patient with rheumatoid arthritis, to establish an individual nursing care plan for a patient with rheumatoid arthritis, and to assess actions taken for the benefit of the patient and his environment.

**Method material:** The study involved a 69-year-old patient with rheumatoid arthritis diagnosed 5 years ago. The patient was hospitalized at the Department of Internal Diseases, Gastroenterology, Endocrinology and Diabetology, Cardinal Stefan Wyszyński Provincial Hospital in Lomza.

**Results:** The disease can have a significant impact on the life of the patient and his caregivers, which is why psychological support is important. Patients with RA may experience pain, fatigue, limited mobility, and emotional problems. Psychological support and nursing care can help the patient cope with the disease and its consequences.

**Conclusions:** A nurse is a key person in the care of a patient with RA. The nurse is responsible for assessing the patient's health condition, monitoring treatment, educating the patient and his family, and providing psychological support. She should have the knowledge and skills necessary to properly care for a patient with RA and should be trained in the diagnosis and treatment of RA, rehabilitation and physiotherapy, patient education and psychological support. The nurse should cooperate with a doctor, a rehabilitator, a psychologist and a social worker in order to provide the patient with comprehensive care.

**Key words:** nursing care, rheumatoid arthritis, nursing

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## Introduction

Rheumatoid arthritis is a chronic autoimmune disease of connective tissue. It is manifested by inflammation in the joints, including the small joints of the hands. Rheumatoid arthritis is differentiated from other systemic connective tissue diseases, such as systemic lupus erythematosus, idiopathic inflammatory myopathies of the joints and systemic sclerosis. The diagnosis of RA is based mainly on basic and specialist tests, including: blood count, determination of citrulline antibodies (anti-CCP) and rheumatoid factor, as well as imaging tests, including magnetic resonance imaging, radiographs and ultrasound [1,2]. There are two forms of the disease - serological positive and negative. The forms differ in the presence or absence of autoantibodies in the blood serum: rheumatoid factor in the IgM class and/or antibodies against citrulline peptide [1,2]. In Poland, approximately 0.9% of the adult population is affected by RA. Additionally,

women are three times more likely to suffer from it, and the peak incidence is estimated at the age of 30-50. With age, the disproportion in the incidence of RA between sick women and men decreases [2].

The etiology of rheumatoid arthritis is not fully known. An unknown factor affects the synovial membrane that lines the joint, causing the body to respond with an inflammatory reaction. The consequence of this is its growth and destruction of adjacent structures, i.e. tendons, ligaments, cartilage and even bones. Several probable factors influencing the development of RA have been identified. These include: genetic factors (primarily predisposing to the development of the disease), environmental factors (viral and bacterial infections), gender (female), defects in the functioning of the immune system (the body recognizes its tissues as "enemy" tissues and tries to fight them), as well as factors that are common among other lifestyle diseases, such as stress or cigarette smoking [3,4].

Pain accompanying the disease, swelling, effusions and a feeling of stiffness that increases in the morning hours usually affect the peripheral joints, wrists and other small joints of the hands and feet [3]. At the initial stage of disease development, patients experience systemic symptoms, such as excessive sweating, fatigue, and weight loss. Symptoms of rheumatoid arthritis can be divided into articular and extra-articular. The most common subjective joint symptoms, indicating an ongoing disease, include: joint pain and swelling, and a feeling of morning stiffness [5]. Coexisting inflammations are localized in the metacarpophalangeal and proximal interphalangeal joints of the hands. Rheumatoid arthritis is a disease that gradually devastates the entire body, which over time not only affects the musculoskeletal system, but also involves abnormalities in other processes in the human body [3].

The degree of difficulty in diagnosing RA depends on its advancement. Diagnosing the advanced form is not a problem, while the early form (0-6 months) requires accurate identification and differentiation from other inflammatory diseases of the joints [5]. To diagnose rheumatoid arthritis, imaging methods are used, e.g. computed tomography, magnetic resonance imaging, ultrasound and laboratory tests, e.g. complete blood count with smear, determination of ESR and CRP levels, and, above all, serological testing to detect rheumatoid factor (Rf), which is active in up to 75% of patients. However, it should be remembered that its absence does not completely exclude the absence of developing the disease [6,7].

The current classification criteria, which allow for early diagnosis of the disease and thus increase the possibility of achieving remission and slowing down the development of the disease, were developed by the American College of Rheumatology (ACR) and the European League Against Rheumatism (EULAR) and date back to 2010 [8].

The main goal of treatment is to achieve remission of RA, reduce pain, limit inflammation and changes in joints and, above all, prevent disability. The pharmacotherapy used is mainly based on the use of drugs from various groups, which include: non-steroidal anti-inflammatory drugs (NSAIDs), simple analgesics, corticosteroids, weak opioids, disease-modifying drugs (DMARDs) and the so-called biological drugs interfering with the actions of immune system mediators (TNF inhibitors) [8].

Surgical treatment in the case of rheumatoid arthritis is considered when, despite intensive conservative treatment, there is severe pain and significant limitations in joint movements, making everyday functioning difficult and therefore leading to limitations and disability.

In addition to changes in the joints, which strictly indicate the ongoing disease, there are other extra-articular changes - they concern many systems, which are complications of the ongoing disease process. These pathologies occur, among others: in vessels, kidneys, heart, respiratory system, nervous system as well as haematological disorders, and changes in the organ of vision and skin.

Rehabilitation is one of the most important elements of the treatment of patients with RA. In addition to the basic goal of pain relief, it is extremely important to constantly maintain

and, in the case of visible deficits, improve the patient's physical fitness. Rehabilitation sessions also play a very important role in overcoming psychological barriers - they adapt the patient to life with the disease, require constant contact with the environment, thus preventing the feeling of loneliness or even the development of depression.

When caring for a patient with RA, a nurse works primarily in a comprehensive and multidirectional manner. She is required to have the knowledge needed to participate in pharmacological treatment (i.e. knowledge of drugs and how they are administered, as well as the occurrence of side effects) and diagnostic tests (e.g. checking basic vital parameters and taking blood for diagnostic tests).

Preventive actions aimed at protecting the patient from exacerbation or possible occurrence of the disease include health education among patients and promoting a healthy, hygienic lifestyle, which may protect the patient from additional pain and inconvenience [9,10].

### Assumptions and goals of the work

The aims of the study were to identify care and therapeutic problems in a patient with rheumatoid arthritis and to develop an individual care plan.

1. Identification of care and therapeutic problems in a patient with rheumatoid arthritis.
2. Establishing an individual nursing care plan for a patient with rheumatoid arthritis.
3. Assessment of actions taken for the patient and his environment.

### Material and research method

The study included a 69-year-old patient with rheumatoid arthritis diagnosed 5 years ago. The patient was hospitalized at the Department of Internal Diseases, Gastroenterology, Endocrinology and Diabetology, Cardinal Stefan Wyszyński Provincial Hospital in Łomża. The research material was collected using the individual case method, analysing medical documentation (individual medical order card, patient's medical history), analysing the results of medical tests and measurements. The research tools included an interview, a fever card, a pain intensity assessment questionnaire according to VAS, a physical examination questionnaire, and the Baxter peripheral catheter patency assessment scale. In order to formulate nursing diagnoses as accurately as possible and determine nursing interventions based on an individual nursing care plan, the nursing process method was used. It is important to adapt this scheme to the contemporary needs of the human patient, but also his family or environment, in terms of maintaining, strengthening and/or restoring health [10].

### Case study

A 69-year-old man, in January 2023, was admitted to the Department of Internal Diseases, Gastroenterology, Endocrinology and Diabetology, Provincial Hospital Cardinal Stefan Wyszyński in Łomża. The reason for hospitalization was massive nosebleeds, which, according to the patient, contributed to the

loss of a significant amount of blood (according to laboratory tests carried out in the department, the haemoglobin value was 7g/dl). In addition, the patient had increased body temperature (37.5°C), difficulty urinating, and increased pain in the wrist, knee and right hip joints. The inflamed joints were accompanied by swelling, especially in the knee joints. Since 2018 the patient has suffered from rheumatoid arthritis. The laboratory tests performed showed a significant increase in the CRP factor (49.87 mg/l) and a positive RF factor. There was no family history of rheumatoid arthritis. The patient also suffers from comorbidities: essential hypertension (primary hypertension), type II diabetes, and obesity.

At the beginning of the patient's observation, the basic vital parameters were measured: HR 115/49, RR 91, temperature 37.5 °C, body weight 103 kg, height 170 - BMI 35.64 kg/m<sup>2</sup>. The patient complains of headache (according to the VAS scale, rated 2, i.e. mild), difficulty urinating, pain in the affected joints (according to the VAS scale, rated 7, i.e. severe), knee swelling (right knee circumference - 40 cm, left knee circumference - 45 cm), morning stiffness lasting about an hour and chronic fatigue increasingly noticed by the patient and his wife (laboratory tests revealed the patient had megaloblastic anaemia MCV 150 fl.). Due to his illness, the patient constantly takes medications: Solu-medrol, Metex 20 mg 1 pre-filled syringe 1x a week, Siofor 3x a day 500mg, Lorista 2x a day (morning - 100mg, evening 50mg), Gliclada 60mg, Corectin 10mg, Agen 5mg, Diuresin SR 60mg, Cardura XL 4mg, Milurit 300mg. The patient takes non-steroidal anti-inflammatory drugs on average 3 times a week, i.e. Diclofenac 75 mg as needed and Nimesulide 100 mg every 6 hours. Observation of the patient for bleeding that may occur due to large amounts of NLPZ consumed - in 2022. Gastroscopy was performed to assess the stomach walls.

Due to severe and painful swelling, the patient has problems with performing everyday activities, such as performing hygiene activities, getting out of bed, going to the toilet, buttoning buttons or tying shoes. The patient is aware of the existing disease - RA, but has not become accustomed to it, asks a lot of questions, and is concerned about his health condition and limited mobility. The patient does not follow the recommendations to eat a balanced diet nor lose weight. Mr. G.P. does not use stimulants - he has not smoked cigarettes for 10 years, and he has not consumed alcohol for a year. His living conditions are good. On the fourth day of hospitalization, a urine culture was ordered - E. coli was cultured, and targeted antibiotic therapy was started (1 day Zinnat 2x250mg). During the patient's stay in the hospital ward, measures were taken to prevent infection, e.g. observation of the peripheral puncture site, use of the Baxter scale to assess the vascular line inserted into the peripheral vessel (rated at 0 points). The principles of asepsis and antisepsis were observed during contact with the patient. Treatment used: Metex 20 mg 1x1 s.c. 1x a week, Siofor 500mg 3x1 PO, Lorista 100mg-0-50mg PO, Gliclada 60mg 1x1 PO, Corectin 10mg 1x1 PO, Agen 5mg 1x1 PO, Diuresin SR 60 mg 1x1 PO, Cardura XL 4mg 1x1 p.o., Milurit 300mg 1x1 p.o., Exacyl 1mg in 250ml 0.9% NaCl i.v. 1x daily, IPP 20mg 1x1 p.o. During hospitalization, the patient was transfused with 3 units of Concentrated Red Blood Cells (RBC).

## Results

Based on the collected research material and its analysis, the care and therapeutic problems of a patient with rheumatoid arthritis were identified, the goals of care were defined, activities were planned and the level of goal implementation was assessed.

### Nursing diagnosis 1:

Patient's suffering caused by incidental pain occurring when trying to perform daily activities according to VAS 7

**Goal:** reducing pain and helping the patient with everyday activities

### Nursing activities:

1. Determining the circumstances of the occurrence of pain, controlling its intensity, determining the activities and positions in which the intensity of pain increases and those that bring relief.
2. Maintaining pain observation and monitoring charts, and assessing pain intensity according to the VAS numerical scale.
3. Assistance in performing everyday activities such as bathing, dressing, and eating meals.
4. During an incident, properly position the patient in protective positions that reduce the intensity of pain: on an even, nondeformed, hard mattress; the upper limbs placed in 40° abduction, in intermediate positions between external and internal rotation; lower limbs slightly bent at the knee joints by about 10°, feet supported at a right angle.
5. Assessment of the scope and degree of the deficit using a clinical point scale, the Barthel index, and determining the nature of the required assistance in the field of existing dysfunctions.
6. Assistance in moving to the toilet or providing appropriate assistive equipment (stroller, walker, crutches, or canes), and learning how to use orthopaedic equipment.
7. Assessment of the limitations resulting from joint deformations while performing everyday activities, an assessment of muscle strength in the upper limbs, and an assessment of joint mobility.
8. Help given to the patient depending on the level of disability (motivating him to perform independently everyday activities and strengthening the belief that he is able to do it on his own).
9. Assistance in the patient in activities in which the patient needs the greatest involvement of loved ones; partial or complete replacement of the patient in activities that are impossible for the patient to perform.
10. Provide the patient with equipment that can be used in everyday life: a shoe horn with a long handle - making it easier to put on shoes independently, cutlery with thick handles, handles for using a cup, grabbing things that have fallen on the floor, a button fastener, etc.
11. Education of the patient and family in the use of orthopaedic equipment that facilitates the patient's movement and rehabilitation.
12. Drawing the attention of the patient and his family to the

need to adapt the home conditions to the patient's health condition, i.e. handrails on the stairs, handles in the toilet, anti-slip mats in the shower or bathtub, and raising pads on the toilet seat, seat in the shower or bathtub.

13. Encouraging the patient to participate in rehabilitation and use physical therapy treatments, e.g. light and heat therapy, laser therapy, cryotherapy based on an individual therapeutic rehabilitation plan developed on the basis of the patient's condition .
14. Maintaining medical records.
15. Participation in pharmacotherapy and drug supply in accordance with the individual order card.
16. Monitoring and evaluating the therapeutic effect of pharmacotherapy.
17. Documenting actions taken for the benefit of the patient and his environment

**Assessment of the actions taken:** The pain has decreased according to the VAS scale 3.

The patient tries to perform most of the activities independently and with the participation of the physiotherapist, nursing staff and family, although he is motivated due to the advanced disease process, he still needs help. After pharmacotherapy, the pain decreased according to VAS 3.

#### Nursing diagnosis 2:

Patient's discomfort caused by increased swelling in the knee joints in the course of active which exacerbated inflammation.

**Goal:** Reduce discomfort

##### Nursing activities:

1. Observation of the knee joints and possible symptoms for: increasing swelling, warming of the skin, redness, loss of function resulting from active inflammation.
2. Applying cool and dry compresses to the swollen areas to minimize unpleasant sensations.
3. Educating the patient in the assessment of oedema and indication of the possibility of taking measurements and monitoring.
4. Adapting rehabilitation exercises during ongoing acute arthritis.
5. Maintaining medical records.
6. Participating in pharmacotherapy and drug supply in accordance with the individual order card.
7. Assessing the therapeutic effect of actions taken for the patient.
8. Documenting actions taken.

**Assessment of the actions taken:** The patient has greater knowledge about the assessment of emerging oedema. Swelling is still present; it is advisable to continue the activities.

#### Nursing Diagnosis 3:

Patient discomfort due to urinary retention

**Purpose:** Ensuring free flow of urine and preventing complications resulting from urinary retention.

##### Nursing activities:

1. Insertion of a catheter into the urinary bladder upon written order of the doctor.
2. Selection of the appropriate diameter of Foley catheter.
3. Catheterization observing aseptic and antiseptic principles.

4. Taking care of the patient's perineal hygiene after inserting the catheter.
5. Maintaining privacy while toileting the perineum.
6. Urine collection for general and bacteriological examination ordered by a doctor.
7. Observation focused on dysuria symptoms (burning during micturition, abdominal pain, painful urge to urinate, and urination in drops).
8. Observation of the quantity and quality of urine excreted: quantity, colour and density, odour, foaming during micturition.
9. Observe the patient's urethral opening for redness and swelling.
10. Participation in pharmacotherapy, supply of drugs in accordance with the individual order card.
11. Assessment of the therapeutic effect of drugs used.
12. Documenting actions taken.

**Assessment of the actions taken:** The urinary bladder is systematically emptied. Microbiological examination of urine confirmed the presence of *E. coli*, and as ordered, targeted antibiotic therapy was initiated (1 day Zinnat 2x250mg).

#### Nursing diagnosis 4:

Discomfort caused by low-grade fever (37.5°C).

**Goal:** Relieving discomfort

##### Nursing activities:

1. Measurement, assessment and documentation of temperature in the fever card.
2. Monitoring heart rate and blood pressure values, and documenting the results.
3. Applying cooling treatments to the forehead area.
4. Ensuring a favourable microclimate in the hospital room (temp. 16-19°C, humidity 50-60%).
5. Moisturizing the oral mucosa, increasing fluid intake below 37°C.
6. Taking care of the patient's body hygiene.
7. Taking care of the hygiene of the patient's personal underwear (if necessary, changing pyjamas and bed linen).
8. Minimizing factors that intensify unpleasant experiences, e.g. noise, light.
9. Participation in pharmacotherapy and drug supply in accordance with the individual order card.
10. Evaluation of actions taken.
11. Documenting actions taken for the patient.

**Assessment of the actions taken:** Body temperature dropped to 36.6°C. The patient confirms improved well-being and comfort.

#### Nursing Diagnosis 5:

Risk of vascular line inflammation due to peripheral cannula insertion

**Goal:** Prevention of inflammation of the peripheral vascular line

##### Nursing activities:

1. Installation of the vascular line in accordance with the principles of asepsis and antisepsis.
2. Maintaining cleanliness around the injection site.
3. Changing the dressing securing the vascular line as needed.

4. Observation of the injection site for signs of inflammation according to the Baxter scale.
5. Using sterile plugs.
6. Flushing the cannula with 0.9% NaCl solution every 4 hours.
7. Compliance with the rules of asepsis and antisepsis .
8. Replace cannula every 72 hours or as needed.
9. Documenting actions taken

**Assessment of the actions taken:** No signs of inflammation of the vascular line were found (0 points on the Baxter scale).

#### **Nursing Diagnosis 6:**

Discomfort due to morning stiffness associated with a chronic, progressive disease process.

**Goal:** Minimizing morning stiffness and improving muscle tone.

##### **Nursing activities:**

1. Including the patient to actively participate in the rehabilitation process - therapeutic rehabilitation and therapeutic education.
2. Preparation of necessary utensils and assistance in performing the morning body wash.
3. Instructing the patient to stay in bed and limit joint mobility during incidents of inflammation.
4. Education of the patient and his family in performing passive and active exercises, i.e. flexing and straightening joints while unloading, exercises in water, rehabilitation of limbs and spine in water.
5. Ensuring the proper equipment of the bed and the use of amenities: providing a stiffened mattress, rollers, wedges, ladders, side rails, and suspensions - if possible.
6. During an incident, properly position the patient in protective positions that reduce the intensity of pain: on an even, undeformed, hard mattress; upper limbs placed in 40° abduction, in intermediate positions between external and internal rotation; lower limbs slightly bent at the knee joints by about 10°, and feet supported, at a right angle.
7. Patient education about the necessity and principles of using painkillers and anti-inflammatory drugs.
8. Observe the patient for reaction to exacerbated disease symptoms.
9. Maintaining medical records.
10. Participation in pharmacotherapy and drug supply in accordance with the individual order card.
11. Documenting actions taken

**Assessment of the actions taken:** The patient's discomfort due to stiffness was reduced. It is advisable to continue long-term activities.

#### **Nursing diagnosis 7:**

Risk of joint deformations and muscle contractures in the joints affected by the disease.

**Goal:** Preventing joint deformations and muscle contractures.

##### **Nursing activities:**

1. Providing a bed with a firm and even mattress.
2. Applying and teaching the patient exercises and methods to prevent deformations and contractures.
3. Applying and educating the patient and his family how to

place the lower limbs in a straight position with the knees raised by 10° and how to immobilize the lower limbs on the sides to prevent ankle rotation.

4. Application and education of the patient and his family in the external rotation position of the upper limbs and in the prone position with the feet placed outside the mattress in order to prevent contractures and deformations in the limbs.
5. Maintaining medical records.
6. Documenting actions taken for the patient.

**Assessment of the actions taken:** The patient was educated about the development of deformities and muscle contractures. Continued action recommended

#### **Nursing Diagnosis 8:**

Increased risk of fall or injury due to exacerbation of RA disease.

**Goal:** Minimizing the risk of falls and injuries and educating the patient and his family about various possibilities of preventing them at home and in the patient's living environment.

##### **Nursing activities:**

1. Familiarizing the patient with the topography of the ward, drawing attention to particularly dangerous places that may cause injury, e.g. signs warning about slippery floors, protruding slats, and unfamiliarity with the rooms.
2. Patient education in the use of facilities and assistance provided by the hospital, e.g. wheelchairs, crutches, walkers, railings, and ladders.
3. Using socks containing ABS to stabilize the foot in shoes - especially slippers and flip-flops.
4. Education of the patient and his family on how to avoid hazards in the home environment, e.g. cables lying on the floor, high thresholds, carpets, and poor lighting.
5. Patient education regarding the selection of comfortable, stable footwear that covers the entire foot; giving up flip-flops and shoes that may pose a risk of falling.
6. Maintaining medical records.
7. Documenting actions taken.

**Assessment of actions taken:** The patient and his family know the potential causes of falls and the possibilities of eliminating them.

#### **Nursing diagnosis 9:**

Increased risk of lipodystrophy and skin lipohypertrophy due to subcutaneous administration of Methotrexate.

**Goal:** Minimizing the risk of subcutaneous tissue atrophy and hypertrophy.

##### **Nursing activities:**

1. Frequently changing needle insertion sites to administer the drug and drawing the patient's attention to the importance of this action.
2. Observation of places where the drug is administered for redness, thickening, hypertrophy, or tissue loss
3. Patient education in how to use the massager in case of lumps or adhesions.
4. Educating the patient and his family on massage techniques to prevent lumps and adhesions.
5. Maintaining medical records.

## 6. Documenting actions taken

**Assessment of the actions taken:** The patient and his family were educated on the prevention of subcutaneous tissue atrophy and hypertrophy.

**Nursing diagnosis 10:**

Increased risk of infection due to reduced immunity due to the use of immunosuppressive drugs.

**Goal:** Prevention of infections.

**Nursing activities:**

1. Frequent airing of the patient's room.
2. Informing the patient and his family about the increased risk of infection.
3. Isolation of potential sources of infection in hospital and community settings.
4. Patient education to improve immunity through increased supply of fruit and vegetables, and the patient's use of a balanced, high-protein diet.
5. Improving the patient's mobility and performing the learned breathing exercises.
6. Compliance with the principles of asepsis and antisepsis during procedures: using sterile, disposable equipment.
7. Observe the vascular access site for inflammation.
8. Taking care of the patient's body hygiene, cleanliness of personal underwear and bedding, and the surroundings.
9. Maintaining medical records.
10. Documenting actions taken.

**Assessment of the actions taken:** No signs of infection were detected. Continued action recommended.

**Nursing diagnosis 11:**

Risk of complications resulting from chronic use of glucocorticosteroids.

**Objective:** Prevention of side effects of pharmacotherapy with glucocorticosteroids.

**Nursing activities:**

1. Observation of the patient for the occurrence of side effects and symptoms, e.g. gastric ulcer, gastrointestinal bleeding, oedema due to water retention in the body, or Cushing's symptoms (facial swelling, buffalo neck, red skin, etc.).
2. Patient education to recognize the side effects of glucocorticosteroids, i.e. gastrointestinal bleeding, increased blood pressure (stabilized in the patient).
3. Monitoring blood pressure measurements three times a day and documenting the results in a self-monitoring diary.
4. Control of blood glucose values and possible deviations from the norm and documenting the results (the patient's diabetes is stable).
5. Encouraging the patient to adopt a hygienic lifestyle, reduce stress, and use relaxation techniques.
6. Educating the patient to improve his immunity by providing an increased supply of fruits and vegetables and following a high protein diet containing unsaturated fatty acids, including: fish.
7. Participation in pharmacotherapy and drug supply in accordance with the individual order card.

8. Observation of the therapeutic effect of the applied pharmacotherapy.

9. Documenting actions taken for the patient

**Assessment of the actions taken:** No side effects were observed. Continued action recommended.

**Nursing diagnosis 12:**

Risk of gastrointestinal bleeding due to chronic use of nonsteroidal anti-inflammatory drugs.

**Goal:** To prevent side effects of using NSAIDs.

**Nursing activities:**

1. Observe the patient for gastric bleeding (epigastric pain, green vomiting, tarry stools, or a drop in blood pressure).
2. Monitoring blood pressure three times a day and documenting the results.
3. Monitoring the amount and frequency of bowel movements, paying particular attention to the presence of mucus and/or blood.
4. Patient education in keeping a diary of medications taken and the frequency of taking them and showing the diary to the doctor during a follow-up visit.
5. Participation in pharmacotherapy and drug supply in accordance with the individual order card.
6. Documenting actions taken.

**Assessment of actions taken:** No bleeding was observed. Continued action recommended.

**Nursing diagnosis 13:**

Patient's lack of motivation to lose weight.

**Goal:** Motivating to reduce weight.

**Nursing activities:**

1. Explaining the planned nutritional treatment to the patient.
2. Explaining to the patient the benefits of weight loss, and drawing attention to the impact of obesity on the development of complications.
3. Control of glycemia level and observation of deviations from the norm, documentation of results.
4. Monitoring blood pressure and documenting the results.
5. Providing the patient with recommendations regarding proper eating habits (the need to eat frequently, regularly and in small quantities 4-5 times a day).
6. Enabling the patient to have a dietary consultation and plan dietary treatment.
7. Providing educational materials on the principles of a balanced diet.
8. Putting the patient on a diet limiting the intake of fats, carbohydrates and sugars as well as introducing a diet with plenty of vegetables and fruit, and fibre (whole-wheat bread, dry legume seeds).
9. Recommendation to maintain proper water and electrolyte balance by providing the body with approximately 2 litres of fluids.
10. Documenting actions taken for the patient.

**Assessment of the actions taken:** The patient was motivated to take action to reduce weight. Continued action recommended.

**Nursing diagnosis 14:**

Fear caused by the need for hospitalization and exacerbation of the RA disease.

**Goal:** Reducing the patient's anxiety level and getting him used to the disease.

**Nursing activities:**

1. Establishing therapeutic contact with the patient by: showing acceptance, respect, patience, active listening, kindness.
2. Strengthening the patient's sense of security and responsibility for his or her own health and improving its functioning.
3. Reducing the level of anxiety through conversation, listening patiently, showing understanding, and ensuring professional help.
4. Answering questions asked by the patient in accordance with current medical knowledge.
5. Familiarizing the patient with the medical staff.
6. Clarifying all doubts arising from the pathophysiology of the disease and the treatment used.
7. Introducing the patient to other patients with whom he was placed in a common room.
8. Familiarizing the patient with the patient's bill of rights.
9. Familiarizing the patient with the topography and regulations of the department.
10. Documenting actions taken

**Assessment of the actions taken:** A slight improvement was achieved in this respect. The patient requires follow-up.

**Discussion**

The study involved a 69-year-old patient diagnosed with rheumatoid arthritis, which, despite statistics stating that the incidence of RA in women is 3–5 times higher than in men [11], shows that men also suffer from this disease. According to M. Baran et al. [12], comorbidities that significantly complicate the treatment process in patients with RA are diabetes and obesity, which also occurred in the patient included in the study [12]. According to A. Wróbel et al. [13], the patient's age (between 60 and 70 years) is the main factor influencing the intensity of the pain felt [13]. The main problem among patients suffering from rheumatoid arthritis is pain, as pointed out by M. Sierakowska and S. Sierakowski [14]. Clear and transparent methods are used for pain self-assessment. The Visual Analogue Scale (VAS) was used for the patient included in the study. P. Wiland, M. Madej and M. Szmyrka-Kaczmarek [15] indicate that in clinical practice it is the most popular scale for assessing pain in patients with rheumatic diseases [15]. J. Cal-Kocikowska, M. Szulińska, P. Bogdański [16] draw attention to the risks associated with the progression of the disease and the associated complications related to the circulatory system. The common cause of death among patients with rheumatoid arthritis is heart attack, heart failure or stroke. Therefore, the appropriate action is to pay attention and carefully and conscientiously control the basic vital parameters of the examined patient. During the observation of the patient, fear was observed resulting from health deterioration, insufficient knowledge, and perhaps even from an unacceptance of the disease. As noted by I. Dobrucka-Janeczek and

A. Jędryka-Góral, we often talk about the concept of "fighting" a disease, while acceptance is precisely its cessation [17].

1. The nurse is a key person in the care of a patient with RA. Responsible for assessing the patient's health condition, monitoring treatment, educating the patient and his family, and providing psychological support.
2. The nurse should have the knowledge and skills necessary to properly care for a patient with RA. She should be trained in the diagnosis and treatment of RA, rehabilitation and physiotherapy, patient education and psychological support.
3. The nurse should cooperate with a doctor, a rehabilitator, a psychologist and a social worker in order to provide the patient with comprehensive care.

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