CASE REPORT ARTICLE
NURSING CARE SYSTEMATIZATION: FROM THEORY TO A COMPREHENSIVE CARE

SISTEMATIZAÇÃO DA ASSISTÊNCIA DE ENFERMAGEM: DA TEORIA AO CUIDADO INTEGRAL
SISTEMATIZACIÓN DE LA ASISTENCIA DE ENFERMERÍA: DE LA TEORÍA AL CUIDADO INTEGRAL

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ABSTRACT
Objective: to report the nursing care for bedridden patients, residents of the territory ascribed to a Family Health Center by applying the process of nursing according to the Diversity Theory of Cultural Care University of Madeleine Leininger. Method: a descriptive study type experience report, with five patients bedridden, between 22 to 92 years old, in Chapecó-SC. Results: situations were identified that required maintenance, adjustment or re-patterning of culturally defined care. The support team was instrumental in the implementation of home care, which is now recorded in the electronic medical records of patients, favoring continuity and comprehensive care. Conclusion: the systematization of nursing care supported in transcultural care theory provided improvements to the health of bedridden patients and the family, motivating the adherence of caregivers to the care plan. Descriptors: Nursing Care; Home Care; Nursing Education; Caregivers.

RESUMO
Objetivo: relatar a assistência de enfermagem a pacientes acamados, moradores do território adscrito a um Centro de Saúde da Família, aplicando o processo de enfermagem de acordo com a Teoria da Diversidade e Universalidade do Cuidado Cultural de Madeleine Leininger. Método: estudo descritivo, tipo relato de experiência, com cinco acamados, entre 22 e 92 anos de idade, no município de Chapecó-SC. Resultados: foram identificadas situações que requeriam manutenção, ajustamento ou repadronização de cuidados culturalmente definidos. O apoio da equipe foi fundamental na implementação da assistência domiciliar, que passou a ser registrada no prontuário eletrônico dos pacientes, favorecendo continuidade e integralidade do cuidado. Conclusão: a Sistematização da Assistência de Enfermagem apoiada na teoria do cuidado transcultural proporcionou melhorias à saúde do acamado e da sua família, motivando a adesão dos cuidadores ao plano de cuidados. Descritores: Assistência de Enfermagem; Assistência Domiciliar; Educação em Enfermagem; Cuidadores.

RESUMEN
Objetivo: relatar la asistencia de enfermería a pacientes postrados en la cama, residentes de un territorio adscrito a un Centro de Salud de la Familia aplicando el proceso de enfermería de acuerdo con la Teoría de la Diversidad y Universalidad del Cuidado Cultural de Madeleine Leininger. Método: estudio descriptivo, tipo relato de experiencia, con cinco postrados en cama, entre 22 y 92 años de edad, en el municipio de Chapecó-SC. Resultados: fueron identificadas situaciones que requerían mantenimiento, ajuste o reestandarización de cuidados culturalmente definidos. El apoyo del equipo fue fundamental en la implementación de la asistencia domiciliaria, que pasó a ser registrada en el prontuario electrónico de los pacientes, favoreciendo continuidad e integralidad del cuidado. Conclusión: la Sistematización de la Asistencia de Enfermería apoyada en la teoría del cuidado transcultural proporcionó mejorías a la salud del postrado y de su familia, motivando la adhesión de los cuidadores al plano de cuidados. Descriptores: Asistencia de Enfermería; Asistencia Domiciliaria; Educación en Enfermería; Cuidadores.

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INTRODUCTION

The Family Health Program (FHP) - currently recognized as Family Health Strategy (FHS) - was designed to bring the community health services to comprehensive health care, with priority given to prevention, but without prejudice to the services care. In this sense, health teams working in units integrated into the FHS play an important role with the enrolled population, both in the health unit, as at home and in other community spaces. In these spaces, the team must establish relationships of bond and partnership to develop according to the health needs of the local population actions, ensuring comprehensive care through health promotion, disease prevention and curative measures.

As part of the multidisciplinary team, the nurse contributes to comprehensive care to individuals, families, and communities, with the foundation of knowledge and specific nursing skills, integrated into the field of health and interaction with knowledge from other scientific areas. In this sense, the Systematization of Nursing Assistance (SNA) constitutes an important tool, especially in the development of care for patients with the greatest need. The performance of SNA reveals a commitment to improving the quality of patient care, enriching the practice of nurses, raising the professional performance in this process. It also enables nurses to strengthen their autonomy, defining the essence of their professional practice.

The SNA is provided by the Federal Nursing Council (COFEN) in COFEN Resolution N° 358/2009, which reinforces the importance of planning the nursing care and states that its implementation should take place in all areas of health care and all public or private health institutions. The institutionalization of SNA enables work processes more responsive to people’s needs, contributing to the promotion, protection, recovery and rehabilitation of the individual family and community.

The implementation of this guidance has remained challenging in the daily practice of nursing professionals who argue that the excess demand from the population and the few conditions guaranteed by the manager to enter more systematic practices in the routine of services make impossible the development of SNA in its complexity. In this sense, studies about its viability require educational institutions more effective dialogue with professional services to identify, from concrete conditions, challenges and opportunities for implementation of the SNA as a methodological reference in the organization of the work process. Survey of nurses working in primary care in the city of Juiz de Fora-MG in 2006 showed that the nursing consultation is carried out by nurses in a limited way, and pointed out difficulties such as excessive bureaucratic activities, deficiencies in the physical structure of the health unit and team rapport, even though these consider extremely important the comprehensive care, combining theoretical and practical knowledge.

The performance of this care practice met the requirement for training in undergraduate degree in nursing Unochapecó, which provides in its Educational Project the completion of the course conclusion work - TCC - in different scenarios of health care, to create opportunities to develop actions nursing with greater autonomy, but also committed to the real demands of the actors of the service and the community.

The activity reported in this article was inserted in one of the projects approved by the nursing course in the National Program of Reorientation of Vocational Training in Health (Pro-Health), coordinated by the Ministry of Health in partnership with the Ministry of Education. This project - development of compulsory internship in several areas - emphasizes, in particular, the scenarios axis practices, favoring the integration between teaching and service in carrying out theoretical and practical activities. Moreover, it provides important evidence related to the axis of the pedagogical orientation of the Pro-Health, as it provides for the training focused on the student and their accountability in the teaching-learning process, based on the principles of autonomy, solidarity and competence.

The practice scenario involves different actors, each with their ways of life, beliefs, and values that influence and are influenced by social, cultural and political context through coexistence in social networks such as family, neighborhood, work, community organizations. In this perspective, to provide adequate assistance to the family and community context of the selected group, it was decided to apply the theoretical and methodological foundations proposed by Madeleine Leininger, focusing on cultural care.

The concept of culture has been improved over time, exceeding their understanding as “fixed set of traits and patterns of behavior. The culture in this understanding was before the action.” From the symbolic
anthropology, culture is defined as “[...] a map, a recipe, a code through which people in a given group think, classify, study and change the world and themselves. It is because they share significant portions of this code (culture) to a set of individuals with different interests and capabilities and even opposite transformed into a group and can live together, feeling part of a whole.9:308

Conceptualized from Freirean work, the culture expresses the manifestation of the man of the world, as it is the sum “of the whole experience, creation, and recreations linked to the man in his space today and his experience of yesterday. [...] Culture is a shaky ground of meaning, in constant change, presented as the new to come.9:312

Leininger defines care as cultural values, beliefs and ways of life learned and transmitted to assist, facilitate or enable another individual or group to maintain their well-being, health and cope with illness or disability.10 The reported care practice aimed to qualify nursing care for bedridden patients, residents of the territory ascribed to a Family Health Center of Chapecó-SC applying the process of nursing according to the Diversity Theory of and Universality Cultural care of Madeleine Leininger. This theoretical called for the performance of the nursing process by the culture in which the individual is inserted, proposing the Sunrise model for the diagnosis and planning of nursing care,6 model that values and integrates different social dimensions that influence the health of the individual.

**OBJECTIVE**

- To report nursing care for bedridden patients, residents of the territory ascribed to a Family Health Center by applying the process of nursing according to the Diversity Theory and Universality Cultural Care of Madeleine Leininger.

**METHOD**

Descriptive study type experience report, with five bedridden patients between 22 to 92 years old, from March to May 2011, in Chapecó-SC.

**SCENARIO OF PRACTICE**

The reported care practice was developed in one of the 27 Family Health Centers (FHC) in the municipality of Chapecó-SC. The initial phase of this practice was the approach to the practice scenario, through a stage observation of 30 hours, next to the health center in the second half of 2010, when information about the reality of the health service and the territory was obtained. Based on this information and in agreement with the staff, the design of the course conclusion work was prepared, establishing the development of a care of inserted nursing in the Family Health Strategy, with a priority of the implementation of SNA to registered patients by staff as bedridden residents of that territory.

Chapecó is located in the western state of Santa Catarina, with a population of about 180,000 inhabitants, and it is considered a reference for over two hundred municipalities in the region. The health center includes two selected teams of FHS, with approximately 10,176 registered patients in two areas of coverage, each subdivided into eight micro-areas covered by community health workers. In this FHC there are three nurses, one is the unit coordinator, two doctors, two dentists, in addition to nursing assistants, community health workers, among others. From 2010, the team has professionals of the Support Center for Family Health (NASF), which develop activities with the four municipal health centers.

The main source of income of the residents of this area comes from the trade represented by about 480 companies, small, medium and large, especially a refrigerator. Another important aspect favorable to health promotion factor in the community is the existence of several organizations that provide public services as a Social Urban Center, the Social Service of Commerce (SESC), the Community Center for the Elderly, and schools and early childhood education centers.

Delimiting the focus of nursing care of practice care to be developed, there were six bedridden patients identified in the FHC coverage area, five of which participated in the study, and the family of the sixth expressed disinterest. Families who participated signed the Term of Consent - TCLE. Data on patients and their families were collected from medical records and home visits to know their health conditions, relating them to their cultural habits. The description of the nursing history followed the Sunrise model proposed by Madeleine Leininger, and the data systematized from the items: technological factors, religious and philosophical factors, companionship and social factors, cultural values and ways of life, political and legal factors, economic factors and educational factors.10

In nursing diagnosis, the data are analyzed and interpreted, with the nurse having “analysis capabilities, judgment, synthesis and
perception to interpret the clinical data.\textsuperscript{11:47} For Leininger, “there should be a diagnostic statement by the nurse, but the use of values and specific care practices of culture should be used as a powerful direction for nursing practice.”\textsuperscript{12:270} After that, the care plans were defined, always in dialogue with the patient and the caregiver, seeking to make them aware of the need and the importance of each nursing care prescribed. The proposal was also presented and discussed with the nurse of a stage supervisor and other members of the health team, getting their approval and support.

The practice was developed over four home visits to each patient, during the three months of work in the unit. On different occasions, specific situations were discussed on cases with the team, including NASF agents, defining together the best action for each patient. The evaluation of the assistance was carried out throughout the process and the last home visit to identify improvements in health conditions, as well as adherence to the care plan, checking facilities and difficulties perceived by the caregiver in their application. Flower names are used to refer to lines that illustrate the results to preserve the identity of patients.

\textbf{Application of the systematization of nursing care}

Initially, the information from medical records and the records of the Primary Care Information System (SIAB), available in the FHC provided basic data on the profile and diagnosed morbidity situations. They found little information on recommended therapeutic prescriptions or about the care provided by the staff in the patient record. In the case of nursing, the non-use of the nursing process limited the access of patient information, as recommended in Resolution N\textsuperscript{458/2009} COFEN, which provides for the mandatory use in all environments where nursing care occurs.\textsuperscript{5}

A nursing process is a methodological tool that guides nursing care and subsidizes the staff in decision-making, promoting continuity of care, their efficiency, and effectiveness. As for records of patient information, the COFEN Resolution N\textsuperscript{458/2009} points out that it is “[...] responsibility and duty of nursing professionals in the patient’s record [...] the inherent information to the care process and the management of work processes needed to ensure continuity and quality of care.”\textsuperscript{5:288}

The Systematization of Nursing Assistance (SNA) has been used in different health institutions, and it is a “scientific methodology that the nurse applies his scientific and human, technical knowledge in patient care.”\textsuperscript{11:09} It enables organization of health work through the use of the nursing process, “which can be understood as the practical application of nursing theory in patient care.”\textsuperscript{13:675}

The first home visit provided relevant data to complement the nursing history, providing an opportunity an important moment of the interaction of students with patients, their caregivers, and other family members. It enabled to establish the therapeutic communication, understood as “interaction process in which we share messages, ideas, feelings, and emotions can influence the behavior of people who, in turn, will react from their beliefs, values, life history, and culture.”\textsuperscript{14:52}

The information obtained during the visits enabled the definition of nursing diagnosis and plan of care, considering the Sunrise model proposed by Leininger, seeking to provide culturally congruent care actions. Leininger notes that the nurse must plan the patient care that needs to be preserved/maintained, accommodated/traded or re-patterning/restructured.\textsuperscript{10}

As primary caregivers, there were family and female professionals, showing then, one of the roles assigned to women by the social environment. In most cases, when it comes to caring or accompany a family member in hospital situation, being a son, husband, mother or father, it is the woman who is implicitly associated as the main family caregiver.\textsuperscript{15}

The Family Health Program (FHP) is one of the strategic activities to home visit that allows the team to know the family arrangements and faced health problems, valuing their resources, their initiatives, and capabilities. Thus, it can be approached the real needs of the community as a means to structure more adequately the health actions.\textsuperscript{16}

Caring at home involves new ways of doing and know the nurse, considering the home environment has different characteristics of a formal health institution. The home environment is permeated by various cultural aspects “of significance to its residents and regulars full of subjectivities not always understood by those who do not reside or attend that environment.” These aspects must necessarily be observed and considered by the
nursing staff when proposing interventions at the home level.\textsuperscript{17, 3501}

There were several visits to compose the historical patient obtaining the information necessary to define diagnoses and develop coherent care proposal with own cultural elements of families, enabling the formulation of consistent care plans considering the concept of culture, which in the design of Leininger “it is the values, beliefs and shared practices, seized in several generations.”\textsuperscript{18, 91}

Culture refers to a cumulative process resulting from historical experience of previous generations.\textsuperscript{19}

Another difficulty faced was the nursing diagnosis, because the texts consulted concerned only that, after identifying the diversity and universality of cultural care, nursing diagnosis expressed areas in which the patient is not filling the cultural expectations of his culture\textsuperscript{10}. According to Leininger, diagnosis refers to deficits that the patient presents that require maintenance, adjustment or re-patternning\textsuperscript{10}, assessment should be based on other areas of knowledge that underpin the process of nursing decision making. Standards related to comfort, cleanliness, elimination, ambulation, recreation and religion were the main deficits identified and included in the care plan.

To carry out the care plan, there was the support of academic course of pharmacy, in addition to professionals from NASF (as a nutritionist and social worker) and FHC health team. Teamwork is referred to in different policies as one of the guidelines of the Unified Health System (SUS), to “interdisciplinarity, thereby contributing to the achievement of comprehensive and good-quality care.”\textsuperscript{20, 339}

The multi-professional work was important to exercise abilities conferred on nurses, providing opportunities for the development of skills such as communication and leadership, seeking to motivate the involvement of professionals in the discussion of cases and their co-responsibility for the care.

Two cases were selected to exemplify the relevance of the Systematization of Nursing Assistance (SAE) and multi-professional work: Margarida, bedridden for three years, and Violeta, with tetraplegia two years ago. The results presented a summarize of the information obtained from the patients and their caregivers, ordered according to the Sunshine model theory of diversity and universality of cultural care of Leininger. There were scores not identifying relevant political factors in the process.

\textbf{Technological factors}

The patient uses the nasogastric tube (NGT), exchanged in the hospital for three to six months; food, prescribed by a nutritionist, since it is specific to enteral nutrition and provided by the Secretary of State for Health, supplemented by liquid foods/paste orally. She uses tracheostomy exchanged at the Regional Hospital of the West of Santa Catarina (HRO) as the physician’s discretion. It is held nasoendotracheal aspiration at night or as needed. Nebulization is performed three times daily as needed and oxygen therapy. She remains in therapy chair alternating with hospital bed borrowed by HRO. The family uses radio and television in the common room. (Margarida)

For her locomotion, she uses a wheelchair. She watches television, uses computer adapted to the chin to hold readings and communicate. (Violeta)

\begin{table}[h]
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\begin{tabular}{|l|}
\hline
1. \textit{Preservation of Cultural Care}  \\
\hline
\textbf{Margarida}  \\
\begin{itemize}
\item a) Performing exchange of the nasogastric tube periodically.  
\item b) Keeping airways permeable through nasoendotracheal aspiration and maintaining high headboard 30\degree.  
\item c) Keeping the cylinder O2 oxygen, ensuring availability and access.  
\item d) Providing moments of relaxation and listening to the radio and watching TV.  
\item e) Preserving hospital bed and therapeutic chair in great condition, to ensure comfort and physical integrity of the patient.  
\item f) Providing sterile equipment for dressing change tracheostomy daily.  
\end{itemize}  \\
\hline
\textbf{Violeta}  \\
\begin{itemize}
\item a) Keeping the wheelchair in safe conditions of use.  
\item b) Having access to the computer.  
\end{itemize}  \\
\hline
\end{tabular}
\end{table}

\begin{table}[h]
\centering
\begin{tabular}{|l|}
\hline
2. \textit{Negotiation of cultural care}  \\
\hline
\textbf{Margarida}  \\
\begin{itemize}
\item a) Evaluating the frequent signs of infection (heat, redness, pain, edema) at the tracheostomy place.  
\end{itemize}  \\
\hline
\textbf{Violeta}  \\
\begin{itemize}
\item a) Encouraging the mother to build a ramp.  
\end{itemize}  \\
\hline
\end{tabular}
\end{table}

\textbf{Religious and Philosophical Factors}

She has visits by pastors and ministers at their residence, the family claims to be Catholic but also attends evangelical church. (Margarida)
The patient goes to church when she is ready. (Violeta)

**DECISION AND ACTION NURSING CARE**

1. **Preservation of the Cultural Care**
   - **Margarida**
     a) Keeping regular visits of religious at home.
   - **Violeta**
     a) Helping the patient getting to the church.

**Social and Kinship Factors**

Widow eight years ago, two children, a girl and a boy 19 and 14 years old, respectively. She had another relationship, with whom she had a son, now 3 years and 9 months, living with his paternal grandmother. She lives with her mother, 64 years old, literate, having her grandson’s help in housework and for the child in financial matters and transport. Regarding care during the day, it is done by two nursing techniques, one at every shift; the overnight caregiver is the mother. (Margarida)

She lives with her mother and three years old sister. On weekends she is visited by her boyfriend. The main caregiver is the mother who has the help of her aunt and boyfriend. When asked if she had time to perform her personal activities, the mother reports that she can come out when someone else stays with her daughters. (Violeta)

**Cultural Values, Beliefs, and Ways of Living**

She has total dependence for daily activities, the absence of voluntary movements, only stimuli; She does not speak but responds through looks and facial movements (non-verbal communication). She does not carry out activities outside the home. In the morning, while receiving bed bath, the radio is turned on to listen to music and then she enjoys watching television. She receives home visits of family health team once a month, the dentist every 6 months or as the family considers necessary. When she needs consultations with medical specialists, she looks for particular care. For physical activities, she receives home care from a professional physical therapist twice a week. Because of the need to use a nasogastric tube, she has to monitor of a nutritionist of the West Regional Hospital or private when necessary. For intestinal and urinary eliminations, she uses diapers, five packs of which are provided monthly by the Social Assistance Reference Center (CRAS), the rest is purchased. According to the nursing technique, the patient is constipated, being held the manual removal of fecalomas. To stimulate peristalsis, laxative foods are used, massage and passive exercise. (Margarida)

As for the personal care, the patient is totally dependent (quadriplegia). The CHA visits her every month and the dentist every six months. As for consultations with other professionals, she has psychological and psychiatric support. Currently, she has a particular physical therapist once a week. The collection of a cervical screening test is performed in her home once a year. Regarding food, the diet is free but undiversified; not always eating fruits and vegetables and not taking the recommended amount of water, because, according to her mother, she does not like it. The bladder deletions are through relief catheter four times a day. She uses diapers due to urinary incontinence. Intestinal eliminations are made before bathing in the toilet. During home visits, it was found that the patient had recurrent urinary tract infection pictures. There was a recent laboratory test at the time the identification of bacteria found in the skin, suggesting that there was exogenous contamination. It was observed that the mother held four bladder catheterization relief daily, from what has been proposed to monitor the implementation of this procedure, and found that the aseptic
Economic Factors

Physical therapy, nursing, and transportation are funded by the brother. (Margarida)

According to the mother, the patient receives sick pay, no health insurance; - they schedule a home visit to the doctor and the nurse when necessary. The main caregiver is the mother, 43, also having the financial support of the father. (Violeta)

Education Factors

Patient with incomplete Elementary School (7th grade), she worked in industrial production. Mother 64 years old, literate. (Margarida)

Incomplete higher education, she attended to the 3rd semester of social service. (Violeta)

DECISÃO E AÇÃO DE CUIDADO DE ENFERMAGEM

1. Negotiation of the cultural care
   Violeta
   a) Stimulating research on topics of interest in the computer.
   b) Providing reading material on advances related to stem cells and other readings, books, magazines.

It was found that most of the proposed care plans are characterized as maintenance, requiring the recognition and appreciation of the caregiver’s knowledge. The preservation/maintenance of cultural care includes actions and professional aid decisions, supportive, facilitative, or enabling that help person of a particular culture to retain and/or preserve relevant values of care, so they can maintain their well-being, get over if the disease or face the disability or death. 10

The nurse in his care practice, when guided by Freire ideas, can recognize an apprentice, next to his patient, “when you see the care as well as health education activity, not realizing the owner of care, not having a vertical attitude in the holistic care act.” 21:835

After the development of the care plan, it was adapted in language accessible to caregivers, avoiding or “translating” technical terms, being delivered during the penultimate home visits made to patients, explaining to every care and its importance to families and caregivers. On the last visit to review, the proposed care was conducted. In Sunrise model, Leininger does not specify a period for evaluation. However, when talking about the transcultural nursing care, she stresses the need for nursing care provide ways that benefit the patient, to determine which are appropriate for healing and well-being that way of life. 10

In evaluations conducted with caregivers about the care implemented to patients from the proposed plan, difficulties and facilities they had about the delivery of care have been
identified. Most reports revealed that the care previously performed continued to be developed, but with built-oriented adjustments and re-patterning of some practices identified as essential, from which one can observe improvements in the tables initially presented by the patients. As reported a caregiver, “care becomes routine” with the risk of not performing some basic care to maintain the quality of life, even more in the case of dependent patients, who are often assisted by the family without preparation and proper support. For this caring, guidance and received motivation in home visits it was essential to promote reflections on the need and the possibility of improving the care provided to bedridden patients, but also for the right of self-care, recovering their self-esteem and well-being.

As a contribution to the FHS team, data were recorded for the nursing process in the medical records of patients by promoting continuity of care provided by professionals. In the case of the FHS, the SNA must be performed from the priorities on the needs of patients belonging to the area of coverage of the FHC, including promotion, protection and recovery of health from individuals, families, groups and community. SNA can strengthen the role of the health care team in the community, facilitate diagnostic, planning and evaluation of assistance, more consistently when supported in culturally significant parameters for those involved.

**FINAL CONSIDERATIONS**

Nursing plays an important role in the consolidation of the Family Health Strategy, priority in guiding the organizational model of primary health care. In this regard, visits and care in the home can not only foster relationships of trust and bond professionals with the community but also creates opportunities for implementation of the principle of comprehensiveness, when and potential needs of patients are recognized and valued in the planning and implementation of care.

As the required dialogic practices on maintenance, negotiation, and/or re-patterning, according to the proposal of transcultural care of Leininger, the experience provided an opportunity for greater ownership of communication and leadership skills. The proposed by Leininger requires professional nursing build an expanded look, undressing of their preconceptions and see the inserted individual in their culture. However, as it brings abstract concepts, it can hinder the understanding of its applicability.

In this sense, the systematization of nursing care is revealed as an important instrument of practice, allowing qualifying the planning, implementation and evaluation of care. In healthcare practice of this report, this instrument showed support in the qualification of the dialogue with other health team professionals and families who provide home care. Thus, it was sought to instigate the health team, especially the nursing staff, to the importance of systematization of care and the multidisciplinary work, promoting bonding with families, critical to the process of care.

**REFERENCES**


