




EXPERIENCE REPORT

Systemic Lupus Erythematosus: case report using the Nursing Process


Lúpus Eritematoso Sistêmico: relato de caso utilizando o Processo de Enfermagem

Lupus Eritematoso Sistêmico: reporte de caso utilizando el Proceso de Enfermería

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ABSTRACT

Objective: to apply the Nursing Process to a patient with Systemic Lupus Erythematosus who developed chronic kidney disease and diabetes mellitus. **Method:** this is a case study developed throughout the practical activities of the Nursing Care Systematization discipline during a Nursing Course in the city of Caxias, MA. The data was obtained through anamnesis and insightful examination physical, from which the nursing diagnoses and planning were elaborated and the necessary interventions and evaluations were performed. **Results:** the results were presented over the Nursing Process applied to the patient in question through the collection of information, making it possible to do a critical judgment of each diagnosis presented by the patient, as well to establish the expected results, implementations and evaluation of Nursing in a systematized and individualized way. **Conclusion:** the systematic and individualized assistance allowed better organization of work and nursing care besides enable greater understanding of the patient about their condition and acceptance process.

Descriptors: Lupus Erythematosus. Systemic. Nursing Process. Case Reports.

RESUMO

Objetivo: aplicar o Processo de Enfermagem a uma paciente com Lúpus Eritematoso Sistêmico, que desenvolveu doença renal crônica e diabetes mellitus. **Método:** trata-se de um estudo de caso desenvolvido durante as atividades práticas da disciplina Sistematização da Assistência de Enfermagem, de um Curso de Enfermagem da cidade de Caxias, MA. Os dados foram obtidos por meio da anamnese e de exames físicos criteriosos, a partir dos quais foram elaborados os diagnósticos de enfermagem e o planejamento e realizadas as intervenções necessárias e as avaliações. **Resultados:** os resultados foram apresentados por meio do Processo de Enfermagem aplicado à paciente em questão por meio do levantamento de informações, possibilitando fazer o julgamento crítico de cada diagnóstico apresentado pela paciente, bem como estabelecer os resultados esperados, implementações e avaliação de Enfermagem de forma sistematizada e individualizada. **Conclusão:** a assistência sistematizada e individualizada permitiu uma melhor organização do trabalho e dos Cuidados de Enfermagem, além de possibilitar o maior entendimento da paciente acerca da sua condição e processo de aceitação.

Descritores: Lúpus Eritematoso Sistêmico. Processo de Enfermagem. Relato de Caso.

RESUMÉN

Objetivo: aplicar el Proceso de Enfermería a un paciente con Lupus Eritematoso Sistémico, que desarrolló enfermedad renal crónica y diabetes mellitus. **Método:** se trata de un estudio de caso desarrollado durante las actividades prácticas de la disciplina de Sistematización de la Atención de Enfermería, de un Curso de Enfermería en la ciudad de Caxias, MA. Los datos fueron obtenidos mediante anamnesis y exámenes físicos criteriosos, a partir de los cuales se elaboraron los diagnósticos de enfermería y la planificación, y se realizaron las intervenciones necesarias y las evaluaciones. **Resultados:** los resultados fueron presentados a través del Proceso de Enfermería aplicado a la paciente en cuestión mediante la recolección de información, lo que permitió realizar un juicio crítico de cada diagnóstico presentado por la paciente, así como establecer los resultados esperados, implementaciones y evaluación de Enfermería de forma sistematizada e individualizada. **Conclusión:** la atención sistematizada e individualizada permitió una mejor organización del trabajo y de la Atención en Enfermería, además de posibilitar una mayor comprensión de la paciente sobre su condición y proceso de aceptación.

Descriptor: Lupus Eritematoso Sistémico. Proceso de Enfermería. Reporte de caso.

INTRODUCTION

Systemic Lupus Erythematosus (SLE) is a chronic multisystemic inflammatory disease with autoimmune characteristics and unknown etiology, having a wide variety of clinical manifestations, related to genetic, environmental and hormonal factors, predominantly affecting women during childbearing years and it is more likely to develop more severe symptoms in blacks and Asians. It is a potentially serious condition, a vasculitis of the medium and small vessels in which all organs are subject to damage, including those whose function is vital for survival, such as the heart, lungs, kidneys and central nervous system, causing other several and chronic diseases. However, with a new therapeutic arsenal and early diagnosis, the acute crises of the disease can be better controlled ⁽¹⁾.

This study deals with the case report of a patient diagnosed with SLE, who developed chronic renal failure (CRF) and diabetes mellitus (DM). Chronic kidney disease is characterized by the loss of kidney function, being progressive and irreversible, compromising the functions of the kidneys, which are responsible for blood filtration, control of water volume and hormone production, and causing symptoms such as edema in the lower limbs, difficult to control hypertension and proteinuria ⁽²⁾. Diabetes mellitus (DM), in turn, refers to a metabolic disorder of heterogeneous etiologies, characterized by hyperglycemia and disturbances in the metabolism of carbohydrates, proteins and fats, resulting from defects in the secretion and/or action of insulin ⁽³⁾.

Under these conditions, it is up to the nursing team to promote effective and comprehensive care, with a view to improving the quality of life of patients affected by such conditions. In this way the Nursing Process is a methodological tool used in order to make systematic nursing care, guiding the work of the team regarding the promotion of quality of care provided due to clinical reasoning and decision-making, formulating nursing diagnoses and care planning, in addition to implementing the planned actions and evaluating the entire doing ⁽⁴⁾.

This study aimed to apply the Nursing Process in a humanized, comprehensive and individualized way to a patient with Systemic Lupus Erythematosus, who developed chronic kidney disease and diabetes mellitus.

METHOD

This is a descriptive study, of the case study type, with a qualitative approach, applied to a patient affected by Systemic Lupus Erythematosus. The study was carried out between April 11 and 22, 2018, in a public hospital with regional coverage, in Caxias, MA. It is noteworthy that the case report consisted of an activity developed in the sixth block of the Nursing Course at a University Center, referring to an activity in the Nursing Care Systematization discipline. This study was conducted and reported in accordance with the COREQ guidelines (Consolidated Criteria for Reporting Qualitative Research), in order to validate this report ⁽⁵⁾.

The Nursing Process (NP) was used, which is an instrument that provides to the use of a systematic guide for the development of a thinking style that directs the clinical judgments necessary for nursing care. In this sense, for the implementation of the NP, it is essential the participation of qualified nurses and knowledge on the subject, professionals who guide the team in the development of the necessary actions, as well to sensitize the health institution to which act to the importance of implementation and for the benefits of use.

The NP provides a theoretical framework that guides research, establishing Nursing Diagnoses, Planning of actions and Nursing Interventions, which offers the basis for the evaluation of nursing achieved outcomes. Thus, as Tannure and Goncalves ⁽⁶⁾, care is organized in five interrelated and interdependent and recurrent stages, to which: Nursing History; Nursing Diagnosis; Planning; Implementation; and Evaluation

The method adopted for data analysis was the use of convergent care theory, which is presented in four processes: apprehension; synthesis; theorization; and transfer. Thus, the seizure highlighted the set of information obtained throughout the approximation process with the patient and his family; in the synthesis, a summary of the problems and needs was produced; in theorization, the literature on the subject and the available data were analyzed; and in the transfer, the necessary knowledge was applied ⁽⁷⁾.

It is noteworthy that, before submitting this case study for publication, it was submitted to Plataforma Brasil and the Research Ethics Committee, with CAAE number 18693219.7.0000.8007 and opinion 3.560.500. The researchers committed themselves to the norms recommended by the CNS Resolution 466/12 ⁽⁸⁾ and its complements, which deal with the ethical aspects of research involving human beings.

As for the research participant, before starting the case study itself, she was oriented about the research and required to sign the Informed Consent Form, safeguarding her psychophysical integrity, identity, the right not to participate in the study and/or exempt your participation at any time.

The risks arising from the research could be in the embarrassment of the participant when being submitted to the questions specific to the anamnesis and physical examination, due to body manipulation and use of medical-hospital instruments, or even the procedures/interventions necessary to improve their condition of life and health. However, such obstacles were overcome by providing information relevant to the research and highlighting the importance of her participation and confirming the confidentiality of her identity and responses, also making it clear that her participation to being voluntary, would not generate any conflict of interest and no value judgment would be issued on the information provided.

Regarding the benefits of the study, they could be directly felt by the participant, by the health professionals involved in the care provided by the Institution and even by the academics and professors who carried out the case study. In relation to the

patient, it was possible to provide comprehensive, individualized and equanimous care focused on her needs and improvement in her health conditions.

performance of complementary exams, when applicable, according Table 1.

RESULTS

The results are presented through the demonstration of the Nursing Process applied to the patient in question. Thus, initially, the information collected through the clinical history or anamnesis and physical examination will be exposed, including the results of exams contained in the patient's medical record.

STEP 1: Nursing History

This is the first stage of the Nursing Process, it is obtained through the collection of information from the Anamnesis and Physical Examination, together with data regarding the

STEPS 2 and 3: Nursing Diagnosis and Planning

The Nursing Diagnosis, the second stage of the Nursing Process, refers to the judgment about the information obtained in the previous phase and the patient's reactions through the use of critical judgment, in addition to being the basis for the elaboration of the Planning, which is the next step, being made possible from the establishment of priorities and the necessary interventions. Thus, to facilitate understanding, for each Nursing Diagnosis⁽⁹⁾, the Expected Results according to the Nursing Outcomes Classification - NOC⁽¹⁰⁾ and the Nursing Interventions, among those established, according to the Classification of Nursing Interventions, were available. Nursing - NIC⁽¹¹⁾ (Table 2).

Table 1 - Disposition of the Nursing History (history and physical examination). Caxias-MA, 2018.

ANAMNESIS	
Identification	MMFC, female, 54 years old, married, literate, 2 daughters, 3 grandchildren, born and raised in Caxias, MA.
Main Complaint	Weakness, tiredness, swollen joints, high fever and bleeding from the fistula .
History of Current Disease	The patient reports that about four years ago she started to have rheumatic diseases, arthralgias, intense dermatoses and heart disease, as well as drastic changes in blood glucose values, when he received the diagnosis of Systemic Lupus Erythematosus. In addition, approximately, one year ago, she suffered from chronic renal failure and, since then, she has been undergoing hemodialysis three times a week. Currently, is hospitalized for Arteriovenous Fistula (AVF) rupture in the left upper member for four days and fever peak, there are two.
Personal background	Performed a facectomy in the right eye, ligature and colpopereinoласти . Diagnosed with diabetes mellitus.
family history	Mother who died from complications of diabetes mellitus; three brothers with the same pathology. Is not aware of other illnesses in the family .
Social Habits and Life Habits	She worked as a maid, but stopped working due to hemodialysis. Receives aid - illness. She lives with her husband and a grandson in her own house, made of masonry, with four rooms, piped water, electricity, collection and disposal garbage on behalf of the public authorities. She claims to be Catholic, non-practitioner, and does not usually participate in leisure activities because she is always tired.
PHYSICAL EXAM	
Ectoscopy	Patient in Regular General Conditon, conscious, self-oriented, alo and chronopsychically, emotional, tearful, aphasic, febrile, hydrated, hypocorada (+2/4+), normocardic, on hemodialysis.
Head and Neck	Normocephalic, unchanged scalp, gray hair, sanitized, hydrated and with little distribution of hairs; symmetrical face, eyes without changes, spontaneous eye opening, isochoric pupils and photoreagentes; normal hearing acuity Righth and Left; nose without alterations and no deviating septum; unaltered mouth and tongue and impaired dentition; symmetrical neck and venous access scar, midline trachea.
Respiratory system	Symmetrical chest, creptations + in both hemithorax, being more audible at the apex of the right lung, tachypnea, normal thoraco-vocal thrill, normal chest with rapid expansion, without the use of accessory muscles.
Cardiovascular system	Tachycardia, two-step em regular cardiac rate, hyperphonetic heart without murmurs, normotensive, rhythmic, strong, full and symmetrical, peripheral perfusion preserved in members.
Abdomen	Flat, depressible, painless on palpation, no visceromegaly, absence of collateral circulation, normal skin, no lesions, no mass, surgical scars from cesarean section, present hydroaerial noise, tympanic sound .
Digestive System	Regular intestinal eliminations, diet with good acceptance in orally, having six meals/day, oral diet for dialysis and for diabetics.
Genitourinary System	Presents oliguria, physiologically colored urine, absence of secretion, unaltered breasts .
Musculoskeletal System	Left upper limb edema (3+/4+), with local occlusive dressing.
SSVV	Blood pressure: 130x60mmHg; Pulse_ 110bpm, Respiratory frequency= 24rpm and Temperature= 38.2 °C.

Source: Direct research, 2018.

Table 2 - Disposition of Nursing Diagnoses, Expected Outcomes and Nursing Interventions. Caxias-MA, 2018. (To be continued)

DIAGNOSTICS OF NURSING (NANDA)	EXPECTED RESULTS (NOC)	NURSING INTERVENTIONS (NIC)
Impaired gas exchange related to ventilation-perfusion imbalance, evidenced by altered respiratory rhythm, depth	Equilibrium of ventilatory perfusion. 3 - 5	<ul style="list-style-type: none"> • Position the patient to relieve dyspnea; • Listening to respiratory sounds, observing areas of reduced or absent ventilation and the presence of adventitious noises; • Monitor respiratory condition and oxygenation; • Encourage slow, deep breathing and change of position.
Situational low self-esteem related to disturbed body image, evidenced by self-negating verbalizations and reports of feelings of uselessness.	Self-acceptance verbalization 2 - 5	<ul style="list-style-type: none"> • Monitor the patient's self-valuing statements; • Strengthen the identified personal positives; • Transmit confidence in the patient's ability to deal with the situation • Reward or praise the patient's progress toward goals; • Make positive statements about the patient.
Readiness for enhanced knowledge, evidenced by demonstration of knowledge about the topic.	Reputable Health Care Resources 3 - 5	<ul style="list-style-type: none"> • organize information from simple to complex, known to unknown, or concrete to abstract, as appropriate; • Adapt the information to meet the patient's lifestyle/routines; • Offer educational materials that exemplify important information and/or complications; • Provide time for the patient to ask questions and discuss her concerns; • Answer questions clearly and concisely.
Excess fluid volume related to compromised regulatory mechanisms, evidenced by altered pulmonary artery pressure.	Ventilatory perfusion balance 2 - 4	<ul style="list-style-type: none"> • Monitor frequency, depth and effort in breathing; • Record chest movements observing the existence of symmetry, use of accessory muscles and retraction of supraclavicular and intercostal muscles; • Palpate in search for equal lung expansion; • Listening to respiratory sounds, observing areas of reduced/absent ventilation and presence of adventitious noises; • Monitor the occurrence of increased restlessness, anxiety and shortness of breath.
Decreased cardiac output related to altered heart rhythm, as evidenced by Heart palpitations.	Adventitious breath sounds 1 - 4	<ul style="list-style-type: none"> • Listen to heart sounds; • Listen to the lungs for the appearance of crackles and other adventitious noises; • Monitor kidney function; • Monitor laboratory values for electrolytes, which can increase the risk of arrhythmias; • Obtain a chest X-ray if appropriate.
Chronic pain related to Chronic musculoskeletal diseases, evidenced by Proxy report of activity changes and Facial expression of pain.	Description of causative factors 2 - 4	<ul style="list-style-type: none"> • Perform a complete pain assessment, including location, characteristics, onset/duration, frequency, quality, intensity and severity; • Ensure accurate analgesia care; • Investigate the patient's knowledge and beliefs about pain; • Investigate the factors that rileve/worse pain; • Choose and implement a variety of measures (p. G., Pharmacological, non - pharmacological, interpersonal) to facilitate relieve of pain, as appropriate.
Impaired physical mobility related to decreased muscle strength and musculoskeletal impairment, evidenced by Decreased fine and gross motor skills	Walk short distances 1 - 4	<ul style="list-style-type: none"> • Provide a low height bed as appropriate; • Advise on availability of auxiliary devices; • Guide the patient/caregiver on ways to position themselves during the transfer and walking process; • Help to the patient with the initial ambulation and as needed; • Encourage independent walking within safe limits.
Readiness for enhanced health self-management, evidenced by expression of desire to control the disease (eg, treatment, prevention of sequelae).	Well-developed health behavior performance 4 - 5	<ul style="list-style-type: none"> • Assist the patient to develop confidence her own ability, as appropriate; • Explain how the information will help to reach her goals; • Help the patient to become aware of the susceptibility to complications; • Help the patient to recognize the ability to control the progression of the disease; • Help the patient to realize that the current situation is different from any previous stressful situation.

Table 2 - Disposition of Nursing Diagnoses, Expected Outcomes and Nursing Interventions. Caxias-MA, 2018. (Conclusion)

DIAGNOSTICS OF NURSING (NANDA)	EXPECTED RESULTS (NOC)	NURSING INTERVENTIONS (NIC)
Impaired skin integrity related to mechanical factors, medical devices, shearing forces, Surface friction Pressure over bony prominence) and immobilization , as evidenced by Disrupted skin surface.	Skin integrity. 3 - 5	<ul style="list-style-type: none"> • Avoid using bed linen with a rough texture; • Massage around the affected area; • Avoid providing local heat applications; • Keep bed linen clean, dry and free from wrinkles; • Document the degree of skin/tissue degradation.
Risk for electrolyte imbalance, related to Insufficient fluid volume, Renal dysfunction.	Balance between ingestion and elimination within 24 hours 2 - 4	<ul style="list-style-type: none"> • Monitor the occurrence of manifestations of electrolyte imbalance; • Keep accurate records of ingestion and elimination; • Teach patient and family about the type, cause and treatments for electrolyte imbalance; • Monitor the patient's response to electrolyte therapy; • Monitor vital signs as appropriate.
Risk for infection related to Immunosuppression, chronic illness and invasive procedures	Identification of infection risk in everyday situations 3 - 5	<ul style="list-style-type: none"> • Monitor vulnerability to infection; • Examine the skin and mucous membranes for hyperemia, extreme heat or drainage; • Guide patients and families on ways to prevent infection; • Teach patient and family about the signs and symptoms of infection and when to inform professionals; • Examine the condition of the incision.

Source: Direct research, 2018.

STEP 4: Implementation

Regarding the fourth stage of the Nursing Process, all the interventions mentioned above were implemented and others that could not be demonstrated in this article for reasons of space regulation in terms of pages.

STAGE 5: Nursing Assessment or Evolution

In the last step of the Nursing Process, an assessment of the patient's health conditions was carried out, noting that she obtained a considerable improvement in her general, social-emotional and self - confidence conditions. Surely, the patient came to better understand her condition, adjacent conditions and the necessary therapies, which generated the Health Promotion Nursing Diagnoses. It is noteworthy that the evolution of the second day of hospitalization was made available for knowledge:

Patient on the 2nd Day of Hospitalization (DH) for ruptured Arteriovenous Fistula (AVF) with Regular General Status (RGS) is conscious, oriented, calm, communicative, cooperative, hydrated, hypocorada (2+/4+), acyanotic, anicteric, febrile, walking with assistance. Scalp: hydrated, sanitized and poorly distributed hair. Face: symmetrical and without acne. Eyes: isochoric and photoreactive pupils, preserved visual acuity. Nose: unchanged and sanitized. Mouth: lips unchanged, tongue sanitized, dentition impaired. Ears: symmetrical, without alterations and preserved hearing acuity. Neck: symmetrical, with presence of venous catheter scar. Respiratory System: normal thorax, with decreased thoracic expansion, tachypneic, pulmonary auscultation with reduced breath sounds, presence of crackles in the right apex. Cardiac System: normosphygmus, two-step

em regular cardiac rate with normophonetic heart sounds without murmur. Digestive System: flat, depressible abdomen, painless on palpation, no mass, present air-fluid noises, regular bowel eliminations. Extremities: left upper limb edema (3+/4+), with local occlusive dressing and preserved peripheral perfusion. It presents a lesion in the lumbosacral region. Genitourinary System: Diuresis of dark color, absence of secretion, oliguria. Vital Signs: Temperature: 36.5°C; Blood pressure: 110x60mmHg; Pulse: 81bpm; Respiratory frequency: 28 rpm.

DISCUSSION

SLE is a potentially serious disease , which can cause serious damage to the affected organs, that can lead to the emergence of other acute and chronic diseases, as occurred with the patient in question, who acquired Chronic Kidney Failure, culminating in the need for hemodialysis. The treatment aims to control the disease, aiming at the prevention of acute outbreaks of vasculitis, avoiding the progression of damage to the affected organs and keeping the disease in remission, reducing the impacts on quality of life ^(1,12) .

Nursing presents itself as a professional area capable of offering possibilities that provide SLE patients with an independent and autonomous life based on the identification of risk factors, as well as promoting actions to minimize the problems arising from this disease and its complications, and contributing the maintenance the quality of life.

Among the Nursing Diagnoses (ND) formulated during patient care, the most important ones were presented in this manuscript (Table 2) and, for didactic purposes, they will be subdivided into four groups, according to the main areas affected in a

person with SLE, namely: I) Circulatory, respiratory and regulatory mechanisms; II) Immune Mechanisms; III) Emotional and learning control mechanisms; IV) Motility mechanisms. Thus, referring to the first group, the following ND were found: Impaired gas exchange; Excessive fluid volume; Decreased cardiac output; Chronic pain and Risk of electrolyte imbalance. In the second group: Impaired skin integrity and infection risk. In the third, there are Situational low self-esteem, Readiness for enhanced knowledge and Readiness for enhanced health self-management. In the last group, Impaired Physical Mobility.

Therefore, it can be observed that these ND are related to the main problems presented by a person with SLE, such as immunological, dermatological, cardiovascular, respiratory, rheumatic, emotional issues, etc.; it should serve as a basis for coherent and correct nursing care. A similar research carried out in Fortaleza, CE⁽¹⁷⁾, detected priority in other nursing diagnoses, such as: Imbalanced nutrition: less than body requirements, Fatigue and Anxiety. This may be linked to the multiple facets and forms of development and presentation of SLE among patients, as well as the different stages of development of its symptoms and complications, requiring from nursing professionals an individualized and comprehensive look at the person being assisted.

Similarly, the Nursing Outcomes⁽¹⁰⁾ fixed for this patient, such as ventilatory perfusion balance, self-concept verbalization, skin integrity and others, including determining the current and desired scores in numerical terms, were essential to establish the most appropriate Nursing Interventions. On the subject, the established scores were essential for the daily follow-up of the patient and verification of the achievement of goals for evaluation and decision regarding the conservation or modification of the care provided. Therefore, the greatest deficits observed were related to self-concept verbalization (2 to 5), ventilatory perfusion balance (2 to 4), adventitious breath sounds (1 to 4), description of pain-causing factors (2 to 4), walking short distances (1 to 4) and balance between ingestion and elimination (2 to 4).

It is essential for lupus patients to understand that therapies can provide good life expectancy, and adherence to treatment is essential. For this reason, constant care combined with periodic assessments make all the difference⁽¹⁸⁾. Therefore, the prescription of plausible and achievable results, depending on the patient's conditions and through their involvement and participation, is very important for the continuity of care and expansion of care opportunities.

Regarding, Nursing Interventions⁽¹¹⁾, among those established during the assistance offered, the five most important ones were selected for each ND, aiming at achieving the stipulated goals. Such actions focused from simple positioning to relieve respiratory symptoms, conveying confidence, offering educational materials, investigating pain relief factors, to monitoring renal function or documenting the degree of skin degradation.

Nursing can promote precious interventions to improve the patient's living and health conditions, such as promoting a calm environment for sleep and rest, strictly controlling the fluid balance, checking daily fasting weight, evaluating general and nutritional status, maintaining adequate pressure levels, assising venous access and other invasive devices for phlogistic signs, evaluate pain, administer analgesics, avoid beds with direct sunlight, evaluate laboratory test results, offer urea-based creams for hydration skin, encourage and guide self-care, provide information about the disease and treatment and emotional support⁽¹⁹⁾.

In SLE, drugs like anti-inflammatory drugs, corticosteroids, antibiotics, analgesics, anti-serous drugs, antiemetics and immunosuppressants were the groups of drugs used in the treatment of the patient, seeking to reduce symptoms, control pain, prevent arthritis and skin manifestations, with a view to preventing the progression of the disease to other organs, prevention of gastric ulcers, nausea and vomiting⁽¹³⁾.

The evolution of patients with SLE is variable and requires individualized Nursing Care and careful surveillance by professionals. Accordingly, the diagnoses raised about the patient were based both on real problems and on potential problems related to improving the condition of health. The application of the NP allowed us to verify that the patient evolved with a significant improvement in her clinical condition, and among the improvements we can mention: expansion of knowledge about the disease; emotional support; pain and symptom control; monitoring of organs such as heart, lung, kidneys, etc., which are essential to improve the patient's quality of life and to prevent/contain complications.

For Garcia and Nóbrega⁽¹⁴⁾, the resolution and prevention of identified problems and formulated diagnoses are carried out through Nursing Interventions, which are methods/means used by professionals to be followed for a certain period of time with the objective of improvement and reduction of risks in the patient's quality of life.

In Nursing Interventions, they determined the time, schedule and intervals for the care to be fulfilled in order to develop care in an organized, comprehensive and safe way; both in the period of hospitalization and in the planning of discharge, through the instructions provided. Furthermore, after implementation, the evaluation process took place, in which the benefits of the behaviors were analyzed, seeking results that would favor an improvement in health^(15,16).

The fact is that the NP can and should be applied in all sectors and health services where there is nursing care, including to all people, regardless of age group and health condition. In this sense, a research returned in Maranhão⁽²⁰⁾ deals with an intervention proposal for parents/caregivers of people with Autistic Spectrum Disorder, based on the Adaptation Theory by Callista Roy. Thus, adaptive problems were found in the Physiological Mode, such as indigestion/abdominal discomfort, sleep disturbance, agitation, lack of energy, inability to relax, crying, difficulty concentrating, fear that the worst will

happen, fear of dying; stunning and nervousness; along with in the Self-Concept Mode, referring to issues such as loss of pleasure, irritability, tiredness or fatigue and self-criticism; and also, Function Mode in real life, when they detect devaluation, fear of losing control and indecision; and finally, in the Interdependence Mode, from the loss of interest in sex and loss of interest.

This study enabled the patient to improve knowledge about her condition, even as to know how to improve her health conditions through the provision of information and her care plan, it also enabled the feeling of welcoming and individualized attention, providing well-being and safety. The study also allowed to deepening the knowledge about the conditions presented by the client, enabling to combine theory with praxis, from a closer and individualized contact with her, as making it possible to understand how to act in similar cases, with a view to preventing complications and improving their quality of life.

The limitations of the study were based on the fact it is a chronic and systemic condition and that brings with it a number of changes, and present major complications requiring nursing demands that could not always be met. Furthermore, in the hospital in question, the Systematization of Nursing Care is not fully implemented and the nursing process is not a reality.

CONCLUSION

The case report addressed a patient with Systemic Lupus Erythematosus and chronic renal failure undergoing hemodialysis and diabetes mellitus resulting from the disease. The work was important because it allowed deepening the knowledge about the conditions reported, which made it possible to combine theory with praxis, from a closer and individualized contact with it, as well as understanding how to act in similar cases, with a view to preventing interurrences and improve the quality of life of patients with SLE.

The present work allowed the patient more knowledge about her condition, besides knowing how to proceed to improve her health through the provision of information and her care plan, which also enabled the feeling of welcoming and individualized attention, providing well-being and safety.

Moreover, the use of the Nursing Process in this study ensured the development of organized and systematized care, promoting efficient practice and coherent nursing care, directing critical judgment and decision-making, providing interaction between professionals, students and patients, seeking to improve their self-esteem and their understanding of the disease and acceptance process.

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