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RESEARCH

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Nurses' Role in Emergency Care for Women Victims of Sexual Violence

Enfermeiros frente ao atendimento de urgência e emergência às mulheres em situação de violência sexual

Enfermeros frente a la atención de urgencia y emergencia a mujeres en situación de violencia sexual

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Abstract

Objective: to understand the role of nurses in providing urgent and emergency care to women in situations of sexual violence. **Method:** qualitative study, with an exploratory and descriptive approach, conducted with 15 nurses working in the urgent and emergency care department of a hospital located in a large municipality in the state of Santa Catarina, Brazil. Data collection was performed through semi-structured interviews from July to August 2024, and the results were submitted to Bardin's Thematic Content Analysis. **Results**: three thematic categories emerged, entitled: Welcoming of the victim in nursing care; The nurse's role anchored in the opening of the care protocol and the activation of the multidisciplinary team; and Challenges in the care process. **Final considerations and implications for practice:** nurses play a central role in caring for women in situations of sexual violence, ensuring safe Welcoming and appropriate referrals, requiring professional training and improved resources to ensure quality care.

Keywords: Nursing Care; Sex Offenses; Nurses; Women; Emergency Service, Hospital.

Resumo

Objetivo: compreender a atuação do enfermeiro no atendimento de urgência e emergência às mulheres em situação de violência sexual. **Método:** estudo qualitativo, de abordagem exploratória e descritiva, realizado com 15 enfermeiros assistenciais do setor de urgência e emergência de um hospital localizado em um município de grande porte do Estado de Santa Catarina, Brasil. A coleta de dados foi realizada por meio de entrevista semiestruturada no período de julho a agosto de 2024 e seus resultados foram submetidos à Análise de Conteúdo Temática de Bardin. **Resultados:** emergiram três categorias temáticas, intituladas: Acolhimento da vítima no cuidado de Enfermagem; A atuação do enfermeiro ancorada na abertura do protocolo de atendimento e no acionamento da equipe multiprofissional; e Os desafios no processo de atendimento. **Considerações finais e implicações para a prática:** o enfermeiro desempenha papel central no atendimento à mulher em situação de violência sexual, garantindo acolhimento seguro e encaminhamentos adequados, sendo necessária a qualificação profissional e a melhoria dos recursos para assegurar a qualidade da assistência.

Keywords: Cuidados de Enfermagem; Delitos Sexuais; Enfermeiros; Mulheres; Serviço Hospitalar de Emergência.

Resumen

Objetivo: comprender la actuación del enfermero en la atención de urgencias y emergencias a mujeres en situación de violencia sexual. **Método**: estudio cualitativo de enfoque exploratorio y descriptivo, realizado con 15 enfermeros asistenciales del área de urgencias y emergencias de un hospital de una ciudad de gran tamaño en el estado de Santa Catarina, Brasil. La recolección de datos se llevó a cabo mediante entrevistas semiestructuradas en el período de julio a agosto de 2024, y los resultados fueron sometidos al Análisis de Contenido Temático de Bardin. **Resultados**: emergieron tres categorías temáticas: Acogida de la víctima en el cuidado de enfermería; La actuación del enfermero basada en la activación del protocolo de atención y en la articulación del equipo multidisciplinario; y Los desafíos en el proceso de atención. **Consideraciones finales e implicaciones para la práctica**: el enfermero desempeña un papel central en la atención a mujeres en situación de violencia sexual, garantizando un acompañamiento seguro y derivaciones adecuadas, siendo necesaria la capacitación profesional y la mejora de los recursos para asegurar la calidad de la asistencia.

Palabras clave: Atención de Enfermería; Delitos Sexuales; Enfermeros; Mujeres; Servicio de Urgencias Hospitalarias.

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INTRODUCTION

Sexual Violence (SV) is a serious violation of human rights and a global public health problem, with profound impacts on the physical, psychological, and social health of victims, especially women and girls.[1,2]

According to the World Health Organization (WHO), SV includes any sexual act, attempt to obtain it, unwanted sexual advances or comments, or acts directed against a person's sexuality through coercion, force, or abuse of power, regardless of the relationship between the victim and the perpetrator.[2] It is a complex and multifactorial phenomenon, present in different social and cultural contexts, which reflects gender inequalities and asymmetrical power relations.[1,2]

Rape is the most common and serious type of sexual crime.[2,3] In Brazil, 71,892 cases of rape were reported in 2024, an average of 196 crimes per day, averaging eight cases per hour.[1] It is noteworthy that women are the main victims, representing 88.2% of cases, with gender inequality being identified as the main cause of the high incidence in this population.[4,5]

In Brazil, SV is a persistent challenge, reflected in data that point to a high incidence of cases and the urgent need to improve care networks. Given this reality, the Unified Health System (SUS) emerges as the main gateway and care network for victims, who are supported by specific legislation and public policies that aim to ensure comprehensive and humane care. These regulations advocate a multidisciplinary and intersectoral approach, recognizing the complexity of the phenomenon and the need for actions that transcend the scope of health, encompassing public safety and social assistance.[6,7]

Approximately 80% of victims of sexual crimes seek care at health services within the first 72 hours after the assault,[6,7] where they are identified, reported, and received.[8] Nurses are among the first professionals to have direct contact with women during care, and they must be trained to follow the Welcoming protocol and provide comprehensive support for the needs of users, thereby enhancing the quality of care provided by the multidisciplinary team.[9] However, in practice, factors such as lack of time, work overload, lack of continuing education programs, inadequate physical structures of institutions, and institutional violence stemming from the unethical, prejudiced, and discriminatory attitudes of the professionals themselves contribute to ineffective nursing care and increase the revictimization of women.[10]

In the municipality where this research was conducted, the Protocol for Assisting Victims of Sexual Violence was created in 2009 to guide and conduct, across the entire intersectoral network, humane, qualified, and comprehensive care for victims and their families,[11] in accordance with Ordinance No. 485/2014 of the Ministry of Health (MS), which defines the functioning of the Service for Assistance to Persons in Situations of Sexual Violence within the scope of the SUS.[12]

In acute cases of SV, the municipality's urgent and emergency care network is organized to coordinate and integrate all necessary health equipment, to expand and improve humane and comprehensive access for victims, reducing the harm caused by violence, ensuring access to emergency contraception and prophylactic measures against Sexually Transmitted Infections (STIs), providing humane, agile, and timely care, with privacy and confidentiality of information, in addition to ensuring other referrals.[11]

Given this complex scenario and the need to strengthen assistance to women in situations of SV, this study aims to contribute to the production of knowledge and the promotion of reflection on the theme, improve professional training, support health policies and clinical care protocols, and strengthen the role of nursing, contributing significantly to the qualification of care and the promotion of more effective and humanized care for victims of SV. Thus, the objective of this study was to understand the role of nurses in urgent and emergency care for women in situations of SV in a municipality in southern Brazil.

METHOD

This is a qualitative study of an exploratory-descriptive nature, whose report was prepared in accordance with the items of the Consolidated Criteria for Reporting Qualitative Research (COREQ).[13] The adoption of this tool was considered relevant to ensure methodological transparency and rigor in the presentation of data collection and analysis procedures.

The interviews were conducted by a female student enrolled in the Bachelor of Nursing program, under the guidance of nursing professors with doctoral degrees. During the collection period, the interviewer was an undergraduate student and was responsible for applying the instruments, conducting the interviews, and transcribing the recordings. The supervisors provided technical and contextual expertise to the research: one had a specialization in Women's Health, and the other was a member of the Women's Network to Combat Violence Against Women and the *Agosto Lilás* (Purple August) working group in the municipality where the study was conducted. This articulation between academic training and practical experience contributed to the ethical, sensitive, and reflective conduct of the investigative process, without the interviewer's additional personal characteristics being previously disclosed to the participants, to minimize biases in the interaction.

The research was conducted in a large municipality in the state of Santa Catarina, whose acute SV care network (up to 72 hours) consists of five hospitals and three Emergency Care Units (*Unidades de Pronto Atendimento* - UPA). In 2023, these services totaled 66 notifications. The study site was the urgent and emergency care unit of a public referral hospital, selected because it had the highest number of SV notifications in women over 15 years of age—13 cases in 2023 and 15 in 2024.

Sampling was done for convenience, consisting of nurses with more than six months of experience in the sector and previous experience in caring for women in situations of SV. Professionals with less than six months of experience were excluded, as well as those absent due to vacation, leave, or sick leave. Of the 19 nurses assigned to the sector, 15 met the inclusion criteria and participated in the study.

For the sociodemographic characterization of the sample, a structured questionnaire was applied, containing information related to the participants' profiles. The instrument included variables such as gender, age group, length of professional practice, level of education, and length of service in the health service, as well as questions regarding professional training and capacity building, investigating whether the participant had received specific training in caring for women in situations of SV and whether the topic had been addressed during their nursing degree. The purpose of this information was to describe the profile of the nurses and contextualize their experiences and training within the scope of the study.

Next, a semi-structured interview was conducted with open-ended and guiding questions about the role of nurses in caring for women in situations of SV. The interviews took the form of a guided conversation between the interviewer and the participant. The responses were recorded on the researcher's cell phone. The interview script was prepared by the author, reviewed by the advisors, and was not pilot tested. The questions sought to understand how nurses defined SV; how the first care provided to a woman in this situation was; whether they had received any type of training or capacity building; what activities they performed during care; how they perceived the role of the nurse and the conduct of the care protocol; whether they considered themselves trained; what they thought was necessary to improve their practice, in addition to the strengths and weaknesses identified in the management of the protocol and the main difficulties faced in these care situations.

The collection was carried out in a private room within the hospital's urgent care and emergency department, ensuring the privacy and confidentiality of the information. Participants were approached in person during their work shifts and invited to participate voluntarily, with no refusals. The interviews were conducted using the interviewer's cell phone, individually and exclusively. Each interview lasted an average of about 20 minutes and was recorded in its entirety and transcribed by the researcher. During and after the interviews, field notes were taken with contextual and procedural observations. Theoretical saturation was considered to have been reached when the responses began to show recurring meanings, and the transcripts were not returned to the participants for verification.

The analysis followed Bardin's Thematic Content Analysis, respecting the stages of pre-analysis, exploration of the material, and treatment/interpretation of the results.[14] The transcripts were read thoroughly and coded manually, line by line (without the use of any type of data analysis tool), with the content subsequently organized into a Microsoft Word® table, prepared by the interviewer herself, who grouped nine codes, five subcategories, and three final categories. The themes emerged inductively from the data; no software was used to manage the information, and the participants did not provide feedback on the findings.

To preserve anonymity, each statement was identified by an alphanumeric code (Nurse 01 to Nurse 15). Selected quotes were presented to illustrate the findings, and consistency between the raw data and interpretations was verified, as well as clarity in the presentation of the main and secondary themes.

The study was approved by the Research Ethics Committee (REC) under the Certificate of Presentation for Ethical Review (CAAE) No. 80041024.2.0000.5363 and substantiated opinion No. 6,858,086. The study fully complied with the standards of Resolution No. 466/12 of the National Health Council (NHC), and all participants signed the Free and Informed Consent Term (FICT) and were previously informed about the objectives of the research.

RESULTS

Fifteen nurses (11 women and four men) aged between 31 and 49 years participated in the study. They had graduated between three and 19 years ago and had worked in urgent and emergency care for between one and 13 years. Of the 15 nurses, 13 had specialization, and two had master's degrees. When asked about the approach to SV during their undergraduate nursing education, five did not recall it, and 10 said they had received it. Regarding the training and capacity building received on the topic in their work environment, six stated that they had received three or more training/capacity building sessions, four stated that they had participated in only one, and five had never received training or capacity building on SV.

After the analytical process, three thematic categories emerged: welcoming the victim in nursing care; the nurse's role anchored in opening the care protocol and activating the multidisciplinary team; and the challenges in the care process, as described below.

Welcoming the victim into nursing care

Setting aside judgments and adopting an ethical stance, without making any value judgments, is part of nursing care in the reception area.

> *Our role is not to judge anyone, so you need to be careful about what you say, how you ask questions, and how you welcome people. Even the way you look at them matters, right? Because often you won't judge verbally, but you will judge that patient with your gaze.* (Nurse 12)

> *I think nurses have a different perspective, you know? They learn to be more discreet. We really respect what is happening to women and take an ethical approach.* (Nurse 06)

The Welcoming aims to provide a safe, welcoming, and empathetic environment, ensuring comfort and support for women so that they can grow stronger and continue with the care process.

> *I try to see if she needs anything, a change of companion, or if someone else can come. I ask if she wants me to call someone.* (Nurse 09)

> *We try to make her as comfortable as possible, because we know how difficult that moment is for women [...] I take her to a private room to make her feel as comfortable as possible, so she feels protected.* (Nurse 08)
>
> *Some women are sometimes a little inhibited by the fact that we are men [...] they are afraid because they have been assaulted by a man and now another man is coming to assist them [...]. So, if possible, I ask another nurse to take over.* (Nurse 10)

Active listening and body language are tools used by nurses in the process of welcoming women in situations of SV.

> *I close the screening door and talk to her [...], I give her as much time as she needs to tell me what happened. I don't pressure her for answers. If she wants to and feels comfortable, we talk.* (Nurse 09)
>
> *Countless times, the patient arrives and, just by looking at her, you notice that she is asking for help [...], and for that, you need to have that "feeling." You need to look at her and realize when the patient wants and needs help. Sometimes it will be through a gesture, a look, or a touch. She will want to talk only to you.* (Nurse 12)

In addition, the guidelines provided by nursing staff during admission are intended to promote continuity of care and ensure its comprehensiveness.

> [...] *You will talk to her about the situation, you will advise her that she will undergo other consultations that are also very important, make that clear [...], that she will see social services, the psychologist, the doctor, that she will go to the laboratory, right? So that she understands that she will still be seen by several other people and that this is part of the process of getting help.* (Nurse 05)

The nurse's role is anchored in the opening of the care protocol and the activation of the multidisciplinary team

The nurse's role in the urgent and emergency care sector often begins with triage, where the victim is welcomed, protected, and given privacy to report their suffering. The identification of SV does not always occur at the reception desk, as triage is an initial point of contact, but not intended for a prolonged and in-depth assessment. After identifying violence, nurses open a care protocol to ensure humane, agile, and comprehensive care for victims.

> *First, we identify, screen, and classify the risk [...], because she will seek care, sometimes even for a different complaint at the front desk, she will say that she has some other problem, and then when she comes in, she will open up to the person who is asking what brought her there. Then we identify it.* (Nurse 04)
>
> *[...] I identified that it is violence? I already got the protocol papers, the notification [...] I report everything, the patient's complete data, everything! From there, we call social services, psychology, and the doctors.* (Nurse 10)

The use of a multidisciplinary care flowchart, involving nursing, medicine, social work, psychology, and forensic science, allows care to be provided in an agile and systematic manner, intending to reduce exposure time and the psychological distress associated with care.

> *We ask to speed up the tests so that, depending on when the assault took place, we can determine the appropriate treatment, because there is the whole issue of the immunological window and so on. The sooner we try to speed things up, the better. [...] We already have this perspective, so together with the medical team, we prioritize and activate the multidisciplinary team.* (Nurse 10)
>
> *We try to do it as quickly as possible because she is seen by many professionals: the technician, the doctor, the nurse, social services, psychology, and sometimes the police. So we try not to keep her here too long.* (Nurse 01)

Nurses identified psychological distress as the most significant impact of SV, emphasizing emotional support as the main intervention strategy and the greatest demand for health care among victims.

> *The woman arrives feeling very depressed psychologically, you know? And sometimes with nothing, without any support, nothing [...] it's difficult for the woman, because she talks in a very tearful way to convey this difficult moment to other people.* (Nurse 03)
>
> *I see that the assistance is more psychological than medicinal. Medication helps, of course, it helps her to be calmer, but it is necessary to give greater emotional support.* (Nurse 08)

Furthermore, nurses recognized that implementing strategies to prevent revictimization during multidisciplinary care, so that women must only recount the story of the assault once to one of the professionals, can minimize their psychological suffering.

> *We receive the victim at the risk assessment stage, and from that moment on, we try to limit the number of people who talk to her, because every time we make her repeat her story, we are revictimizing her.* (Nurse 07)

> *Here at the assessment stage, I gather as much information as possible so that she doesn't have to relive what happened. And I explain everything I do, because the more information I give her, the lower the risk of her having to talk to someone else.* (Nurse 09)

Challenges in the assistance process

Time was listed as an important factor in nursing care for victims of SV. However, the lack of time to adequately care for women in situations of SV, reflected in the high turnover of professionals and the high demand for care in the emergency service, was identified as a limiting factor in nursing practice.

> *Everything here is very fast-paced: you do what has to be done, but not how it should be done, right? Because the demand is so high. So, often, we can't cope, we can't welcome people, listen to them. Often, we receive patients and immediately refer them elsewhere, and we don't even get to see the outcome; we only find out during the next shift.* (Nurse 13)

> *[...] the biggest weakness is turnover, because the team changes a lot, right?* (Nurse 01*)*

Privacy, comfort, emotional support, and minimizing exposure during care are all part of nursing care. However, these aspects are sometimes neglected due to a lack of female professionals to provide care.

> *Sometimes she doesn't open up because women feel more comfortable with other women, so sometimes there are no female nurses, only male nurses, which makes it difficult.* (Nurse 04)

Screening is the moment when the victim is welcomed to express her suffering. However, there is limited performance by nurses in the identification process, since most women do not identify themselves as victims at the time of risk classification.

> *Some only tell the doctor at the time because they are ashamed to talk about it, so we don't always identify them; we only find out later.* (Nurse 14)

The lack of training and skills, or even the professional's psycho-emotional unpreparedness to deal with the situation, whether for professional reasons or due to intrinsic characteristics of their personality, are barriers faced daily by nursing professionals.

> *We see that it is quite difficult to identify or even approach them more appropriately. The lack of training is a weakness, because the more training we have, the more knowledge we will have, right? It is easier to approach them, to ask questions without embarrassing them, things like that.* (Nurse 04)

> *I don't feel comfortable treating them; it is a situation I have a psychological block towards, so much so that I've had cases here where I start treating them and end up calling a colleague to continue, because I start to get nervous. I try not to pass this on to the patient, but I feel a whirlwind of things [...].* (Nurse 02)

The environment and physical infrastructure were highlighted as weaknesses and limitations in nursing care, since the lack of an adequate environment for care can promote feelings of insecurity and discomfort for women.

> *There is no appropriate place for her to stay; sometimes she stays in a chair, so there is a lack of structure to receive her. Sometimes there is an isolation bed, and we end up putting her there, so she can be more "separated."* (Nurse 15)

> *The physical structure weighs heavily! We see a hospital that has the same structure as when it was built; it is only changing internally, it doesn't really grow, right? [...] sometimes it's hard to hear; we close the door because people keep interrupting.* (Nurse 13)

The professional's poor ethical stance, expressed through their judgment of the victim, was identified as a weakness that was visible both directly and indirectly. There is a certain attitude and body language that conveys judgment and, as a result, causes many professionals to prefer not to share the case with the team, managing it in isolation.

> *I keep the case confidential so that people don't find out*. (Nurse 08)

> *Sexual violence is a taboo in society; it blames the victim, so there is this judgment on the part of colleagues, right? There are situations where we see judgmental looks, not only from nurses, but from the entire team [...].* (Nurse 07)

DISCUSSION

Welcoming, as observed in this study, is pointed out in the literature as a central axis of nursing care for women in situations of SV.[15,16] When performed by nurses, it helps women feel safe to report the aggression, enabling early identification of violence and the provision of comprehensive care.[17] These actions are in line with the National Policy for Comprehensive Women's Health Care (PNAISM)[18] and Ministry of Health Ordinance No. 485/2014,[12] which recognize welcoming and qualified listening as essential responsibilities of nursing. In this context, nurses have autonomy in conducting the Welcoming and creating bonds with victims, as provided for in national and local protocols.[17]

The use of tools that promote acceptance and continuity of care is a common practice in nursing. Verbalizing aggression requires conditions of empathetic and accessible listening.[19] Thus, active listening, empathy, and providing guidance strengthen trust and the comprehensiveness of care.[20] These strategies are aligned with the Protocol for Assisting People in Situations of Sexual Violence in the municipality in question, which recommends that nurses play a leading role in welcoming and coordinating with the care network.[11]

The use of these resources makes it possible to recognize situations of SV and actively search for suspected cases, considering nonverbal signs in addition to reported complaints.[10,21] Nurses also guide victims about the intra- and intersectoral network, promoting autonomy and continuity of care.[22] Such actions express technical autonomy, according to Ordinance No. 485/2014 of the Ministry of Health,[12] although their effectiveness depends on institutional support and interprofessional integration, which are still limiting factors in the context studied.

However, the testimonies of the participants in this study highlighted the challenges in providing care, such as high demand for care, insufficient staff, and high staff turnover, aspects that are also observed in other studies.[17,19,23] These conditions compromise the comprehensiveness of care and reduce the autonomy of nurses, contrary to the principles of PNAISM and Ordinance No. 485/2014 of the Ministry of Health.[12,18] Turnover leads to the loss of qualified professionals, overload, and insecurity, resulting in fragmented care.[15,23,24]

Nurses recognized the importance of a safe environment and adequate physical infrastructure for treating victims, as recommended by Ministry of Health Ordinance No. 485/2014.[12] Some studies have pointed out the efforts of professionals to ensure privacy and confidentiality during care.[16,21,24] However, the inadequate environment and physical structure of urgent and emergency services compromise the quality of care and limit the full application of municipal protocols. Such conditions can inhibit the reporting of aggression and make it difficult to identify SV.[25]

Furthermore, nurses base their actions on ethical principles, with a respectful and non-judgmental attitude, ensuring dignity, human rights, and continuity of care.[26] In this way, they seek to avoid the revictimization of women, reinforcing the ethical autonomy of nursing, in line with the PNAISM[18] and the National Humanization Policy.[27]

However, moralizing attitudes are still observed in healthcare teams, hindering care.[19] In this study, some nurses reported avoiding sharing cases with judgmental colleagues, preventing new forms of violence. This attitude shows that blaming women for SV still permeates healthcare practices.[9,16,28] In this sense, the recognition by professionals of the need to adopt an ethical and non-judgmental attitude reveals a movement of critical reflection and resistance to practices that perpetuate stigma and gender inequalities in healthcare.[9,16]

Despite these reflective advances, some gaps remain in training and continuing education, making it difficult to identify and adequately manage victims.[15,20,22,23,28] In this scenario, it is necessary to invest in the training of nurses and include the topic of SV in undergraduate courses, promoting technical and relational skills.[16,22,23] Such actions converge with the PNAISM, which emphasizes continuous qualification and the valorization of professional autonomy.[18]

Care for women in situations of SV should be based on skilled listening, empathetic communication, and emotional support, promoting comfort and well-being.[16,19,21,23] Emotional support, recognized as an essential component of care, consists of intentionally offering empathetic and welcoming support through skilled listening and therapeutic presence, aiming to minimize psychological distress and promote emotional security.[23,29] In the context of the Nursing Process, this care is operationalized through communicational and relational interventions, based on the National Humanization Policy and nursing theories centered on integrality and transpersonal care.[27] This dimension reflects an area of greater autonomy, according to Ordinance No. 485/2014 of the Ministry of Health.[12]

In this sense, nurses occupy a strategic position in providing emotional care to victims,[22,29] requiring specific training and multidisciplinary support.[9] In practice, many experience psychological distress in the face of complex cases, which limits their emotional autonomy and reinforces the need for institutional support.[22,29] Even in specialized units, the management of SV is emotionally demanding, especially for nurses who identify with the victims.[19] This suffering is aggravated by inadequate working conditions,[19] and in Brazil, about 40% of nurses show symptoms of Burnout Syndrome, associated with job insecurity.[30] These findings reinforce the importance of institutional policies aimed at emotional well-being and strengthening professional autonomy.[30]

In this circumstance, professional qualifications must go beyond technical expertise and include emotional management. Institutions need to offer psychological support to professionals who work with victims of violence, preventing the psycho-emotional suffering associated with the practice.[20,29]

The adoption of clinical protocols contributes to the qualification of care and the organization of work.[25,26] The literature highlights that these instruments facilitate the identification and approach of victims, reduce revictimization, and favor intersectoral coordination.[5,24] In the context studied, local protocols, aligned with Ordinance No. 485/2014 of the Ministry of Health, reinforce the technical autonomy of nurses, although the scarcity of human and material resources still limits their effectiveness.[12]

Furthermore, the support of qualified multidisciplinary teams represents an advance in the organization of care and comprehensive attention to women.[19] These results showed that, although nursing plays a central and autonomous role in welcoming and listening, it still faces structural and intersectoral barriers that restrict the full effectiveness of policies for caring for women in situations of SV.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The role of nurses in caring for women in situations of SV is fundamental to the quality of care, as it involves treating victims with respect, ethics, and empathy. This care is based on verbal and nonverbal communication skills, which help to establish a bond, providing security and comfort so that women feel safe to report the violence they have suffered. The work of nurses is directly linked to the activation of the specialized care protocol, as well as the referral of victims to the multidisciplinary team, ensuring continuity of health care.

However, nurses face several challenges in providing adequate, quality care, even in the face of institutional limitations, such as the lack of appropriate physical structures, insufficient institutional organization, and a lack of regular training on the subject. In this study, the main weaknesses identified were limited physical resources, work overload, high turnover of professionals, difficulty in identifying victims, insufficient training on clinical protocols, and lack of preparation or psycho-emotional support, factors that compromise the effectiveness of nursing care.

Thus, the findings of this study highlighted the need to strengthen nursing practice through continuing education, institutional support, and the promotion of ethical and humanized care for women in situations of SV.

To minimize these challenges, institutions are expected to implement continuing and lifelong education programs, promoting the development of specific skills in managing care for these women. In addition, providing psychological support to professionals who work directly with this population helps to reduce psycho-emotional distress and prevent burnout. Physical restructuring and improvement of the institutional environment are also important measures to ensure quality care, allowing for more qualified and effective performance, with positive impacts on the patient's experience.

The main limitation of this study relates to the sensitivity of the topic, which depends on the level of openness and emotional vulnerability of the participants. Despite this, the results provided an understanding of the care practices and weaknesses faced by nurses. Although the topic has gained greater visibility in the literature recently, additional qualitative studies are recommended with secondary and tertiary health care professionals, who are the reference in acute care for women in situations of SV. These studies can deepen the understanding of the professional difficulties that impact the quality of care and support new strategies to optimize the performance of nurses in specialized services.

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DATA AVAILABILITY RESEARCH

The content underlying the research text is contained in the article.

CONFLICT OF INTEREST

No conflict of interest.

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