

KNOWLEDGE AND PRACTICES OF NURSES REGARDING THE CARE OF VICTIMS OF VIOLENCE IN EMERGENCY CARE UNITS IN BELÉM-PA*

CONHECIMENTOS E PRÁTICAS DE ENFERMEIROS PERANTE A ASSISTENCIA ÀS VÍTIMAS DE VIOLÊNCIA EM UNIDADES DE PRONTO ATENDIMENTO EM BELÉM-PA*

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RESUMO

Objetivo: Identificar conhecimentos e práticas de enfermeiros perante a assistência às vítimas de violência em Unidades de Pronto Atendimento em Belém-PA. **Método:** trata-se de um estudo qualitativo, descritivo, realizado em uma unidade de pronto atendimento. Coletaram-se os dados mediante entrevistas semiestruturadas por meio de um roteiro, analisando-os a partir da técnica de Análise de Conteúdo. **Resultados:** 1) Conhecimento de enfermeiros sobre sinais clínicos da violência; 2) Tipo de violência mais comum sob a ótica dos Enfermeiros; 3) Assistência de Enfermagem e o acolhimento frente às vítimas de violência; 4) Capacitação profissional para o manejo de enfermagem perante as vítimas de violência e 5) Percepções sobre fluxo e encaminhamentos. **Conclusão:** identificaram-se diversos desafios, tais como a identificação da vítima de violência, a qualidade da assistência, a falta de capacitação dos profissionais e o desconhecimento do fluxo do atendimento.

Descritores: Enfermagem; Percepção; Conhecimento; Violência; Urgência; Emergência.

ABSTRACT

Objective: to identify nurses' knowledge and practices regarding the care of victims of violence in Emergency Care Units in Belém-PA. **Method:** this is a qualitative, descriptive study carried out in an emergency care unit. Data were collected through semi-structured interviews using a script, and analyzed using the Content Analysis technique. **Results:** 1) Nurses' knowledge about clinical signs of violence; 2) Most common type of violence from the perspective of nurses; 3) Nursing care and welcoming of victims of violence; 4) Professional training for nursing management of victims of violence and 5) Perceptions about flow and referrals. **Conclusion:** several challenges were

identified, such as the identification of the victim of violence, the quality of assistance, the lack of training of professionals and the lack of knowledge about the flow of care.

Descriptors: Nursing; Perception; Knowledge; Violence; Urgency; Emergency.

RESUMEN

Objetivo: Identificar los conocimientos y prácticas de las enfermeras sobre la atención a las víctimas de violencia en las Unidades de Atención de Emergencia de Belém-PA. Método: se trata de un estudio cualitativo, descriptivo, realizado en una unidad de urgencias. Los datos fueron recolectados a través de entrevistas semiestructuradas utilizando un guion, analizándolos mediante la técnica de Análisis de Contenido. Resultados: 1) Conocimiento de enfermeros sobre signos clínicos de violencia; 2) El tipo de violencia más común desde la perspectiva de los enfermeros; 3) Asistencia de enfermería y acogida a víctimas de violencia; 4) Formación profesional para la gestión de enfermería ante a las víctimas de violencia y 5) Percepciones sobre el flujo y derivaciones. Conclusión: se identificaron varios desafíos, como la identificación de la víctima de violencia, la calidad de la atención, la falta de formación de los profesionales y el desconocimiento sobre el flujo de atención.

Descritores: Enfermería; Percepción; Conocimiento; Violencia; Urgencia; Emergencia.

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INTRODUCTION

It is known that, in contemporary times, many people are victims of non-fatal violence. Among these are victims of aggression, which result in physical injuries, requiring treatment in emergency care centers, as well as people who suffer other types of physical, sexual, and psychological abuse.

It is warned, however, that individuals who are subjected to some form of violence may not report these facts to health care teams and other authorities.¹

Violence can affect various classes of society, such as men and women, ethnic groups, and age groups, and can also affect certain occupations to a peculiar degree of risk. The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, either actual or threatened, against oneself, another person, or a group that can result in death, injury, or psychological harm".²

The damages, injuries, traumas and deaths caused by accidents and violence correspond to high emotional and social costs and to public security apparatuses, causing economic losses, because of the days of absence from work, because of the incalculable mental and emotional damage they cause to the victims and their families, and because of the years of productivity or life lost.³

In the context of the health system, the consequences of violence are evident, among other things, in the increase in spending on emergency care, assistance and rehabilitation, which are much more costly than most conventional medical procedures. It is estimated that about 3.3% of the Brazilian GDP is spent on the direct costs of violence, a figure that rises to 10.5% when indirect costs and resource transfers are included.³ At this conjuncture, nurses act as protagonists in urgency and emergency care services, since they are involved with specificities and articulations primordial to the management of care to patients with complex needs. The public assisted at the Emergency Room (ER) needs health care with improved scientific basis, with technological management and humanization in the assistance received, in a quick and effective way.⁴

Health professionals should use all of their resources and technologies to help people who have been raped to recover their self-esteem and their capacity for self-care, thus favoring the possibility of reconstructing new existential projects.⁵ Nursing professionals need to be aware of their legal attributions and competences regarding the Law of Professional Exercise and, in addition to knowing and raising awareness, they must assume their responsibilities before these legal precepts.

The nurse is one of the professionals with the greatest presence in the care scenarios, performing actions of identification, prevention, orientation, assistance to victims, and notification of the grievance. The main tools used to identify cases are the anamnesis, physical examination, and the nursing process.¹⁶

The nursing assistance for people in situations or victims of violence favors the planning of strategies to overcome violence and the implementation of public health policies aimed at this

purpose. These professionals have the potential to make differential diagnosis of the injuries caused, as well as to promote inter-sector articulation in suspected or confirmed cases. ¹⁶

The resolution COFEN No. 0564/2017 regarding the competence of nurses determines the prohibition in cases of violence: Art. 64 - To provoke, cooperate, be convenient or omission in the face of any form or type of violence against people, family and community, when in the exercise of the profession. ¹⁷

Although many academic curricula in the health area are not updated regarding the changes related to public policies aimed at violence, this contributes to the training of professionals who are stuck in the biomedical model of care and who do not articulate with the professionals that make up the health service and the various levels of care. This leads the user to migrate within the service in its various levels without resolving the problem, leading the victim to give up seeking help. ¹⁶

Thus, it is essential, in view of the facts presented, to understand the role of nurses in the emergency room when dealing with victims who are victims of violence. Thus, the guiding question is: "Como se desenvolve a atuação do enfermeiro no atendimento a pacientes acometidos por algum tipo de violência em Unidades de Pronto Atendimento 24 horas em Belém-PA?". It is hoped that this study can contribute to the recognition and identification of signs of the various types of violence, making it essential to share the search for knowledge and the formulation of programs for evaluation, diagnosis and treatment of the phenomenon, so that professionals act in accordance with the ethics and current legislation of the profession.

OBJECTIVE

To identify nurses' knowledge and practices regarding the care of victims of violence in Emergency Care Units in Belém-PA.

METHOD

This is a qualitative, descriptive and exploratory study whose approach, besides allowing the unveiling of social processes that are still little known, referring to particular groups, enables the creation of new approaches, review and creation of new concepts and categories during the investigation.⁶

It is informed that the participants were, in total, 16 nurses, selected through theoretical saturation sampling, when no new element is found and the addition of new information is no longer necessary, since it will not interfere in the phenomenon to be studied.¹⁸

Inclusion criteria were: being a nurse working in the emergency care unit with at least one year of experience and knowing theoretically and practically about the theme addressed in the study. Nurses with less than one year experience, nurses who had been working in the unit for more than a year, nurses on vacation or on medical leave during the study period, and nurses who were unaware of cases of violence in the emergency care unit where they worked were excluded.

The study was conducted between March and May 2019 in two 24-hour emergency care units of size III in the city of Belém (PA). Data were collected through an interview with questions that addressed the diagnosis and professional attention during a one-month period, with on-site visits using a pre-established script for the study with open questions about the theme. The nurses were approached individually by the researchers during breaks between care activities, in order not to compromise the routine of services, and invited to participate in the research. The interviews took place in appropriate spaces within the ECU, where the research objectives were explained for consent and signing of the Free and Informed Consent Term (FICT). After that, the interviews began, with the use of a tape recorder to record the information obtained through the answers to the questions contained in the script. For the purpose of identity preservation, the participants were identified by the letter E for Nurse, followed by the order number of participation in the research: E1, E2, E3, and so on.

The script was composed of 6 questions, which allowed for ample explanation to the participants, as follows: 1. how do you identify a victim of violence? 2. when you assist people in situations of violence, what assistance do you provide? 3. have you ever notified a victim of violence? Comment on it; 4. What is the most frequent type of violence?; 5. Have you had any training to assist victims of violence?; 6. To which support service is the victim of violence referred?.

In a later stage, the audios with the answers were listened to and transcribed in full, using the Microsoft Word 2013 program. After that, the data could be analyzed according to the content analysis technique proposed by Bardin, going through 1. Pre-analysis; 2. Exploration of the material; 3. Treatment of results, inference and interpretation. The use of this sequence enabled the categorization, where the speeches were analyzed and grouped into common topics.¹⁹

Regarding the ethical aspects, the study complied with Resolution No. 466 of 2012 of the National Health Council, with submission of the project to Plataforma Brasil, with approval by the Research Ethics Committee of the Brasil Amazônia Integrated College (FIBRA) under Opinion No. 3230702.

RESULTS AND DISCUSSION

The participants of this study were aged between 20 and 50 years, with no representation of age range, where comparative results were observed between two emergency care units in the city of Belém (DAICO) and (DASAC). In this context, 12 (75%) were female, 11 (68.75%) were between 25 and 35 years old, 11 (68.75%) were married, 14 (87.5%) had a complete post-graduation course, 10 (68.75%) had been working for 5 to 10 years and 10 (68.75%) had a classification in the work sector, according to table 1.

Table 1. Profile of professionals at the Emergency Care Units in Belém (PA), Brazil, 2019.

Variables	n =16	%
Gender		
Female	12	75
Male	4	25
Age group		
20 to 25 years	0	0
25 to 35 years	1	68.75
35 to 45 years	3	18.75
45 to 50 years	2	12.5
Marital status		
Single	4	25
Married	11	68.75
Divorced	1	6.25
Complementary training		
Training	0	0
Specialization	14	87.5
Masters	2	12.5
Time of service in the area of urgency and emergency		
Up to 5 years	4	5
5 to 10 years	10	68.75
10 to 15 years	2	12.5
Work sector		
Risk Classification	2	12.5
Red room	1	62.5
Assistance	1	6.25
Supervision	3	18.75

Based on the analysis of the interviews, five thematic categories were identified, which address the nurses' perception of the cases of violence in their care contexts. The categories are as follows: 1) Nurses' knowledge about clinical signs of violence; 2) Most common type of violence from the point of view of Nurses; 3) Nursing Care and the welcoming of victims of violence; 4) Professional training for nursing management of victims of violence and 5) Perceptions on flow and referrals.

Nurses' knowledge about clinical signs of violence

It is revealed that, in this category, two aspects emerged regarding the form of identification of victims of violence. It was noticed that some nurses had full knowledge of how to identify, according to their reports, however, some reported issues of doubt, such as asking the interviewer the correct conduct and considering that only one clinical sign would be enough to identify the victim, which can possibly cause failure in proper care. Among the answers, the understanding of E3 stands out, which has the knowledge to identify a victim of violence through visual signs, such as bruises, edema and emotional state.

[...] if he/she presents classic signs, such as hematomas, edemas, identifying this, according to the patient, he/she arrives very tearful, debilitated, afraid, having difficulty to make him/her tell, it is important to know in order to define the conduct. (E3)

It is understood, by others, that visual signs are extremely relevant to identify violence.

[...] she arrives frightened, crying. We try to talk, the nursing part, before giving assistance, starts to make a conversation, a contact, like a welcoming contact for him to feel welcomed, so he can talk about what he is feeling, because he won't say right away that he suffered an aggression, so we talk, then we evaluate and try to help, give assistance. (E12)

[...] it depends a lot on the violence, obviously, each violence will have its specific characteristic; in the situation of the emergency room, the most common types of violence are urban violence, gunshot wounds, stabbings, violence resulting from some type of aggression, so, how to identify the clinical signs of the patient who arrives here by the previous epidemiological history. (E11)

It was found that some of the nurses have the knowledge to identify a victim of violence through visual signs, such as bruises, edema and emotional state, and that the health team, and especially the nurse, must provide timely, effective, safe and ethical care. A study conducted with nursing students corroborates these findings, by highlighting them as important clinical signs in the identification of violence.²⁰ The provision of care to victims will require the structuring and organization of the UHS service network, so that it can diagnose violence and accidents among users and receive demands, providing them with dignified, quality and resolute care, from the first level of care.⁸

Health professionals should be trained to identify maltreatment, call existing services for the protection of victims, and follow up on identified cases. Adequate conditions for care, such as time for team meetings, supervision, and infrastructure, must be ensured. The use of tools such as the Manchester protocol in the context of urgent and emergency care must be emphasized. Furthermore, the assistance to victims of accidents and violence must integrate the set of activities

developed by the Family Health Strategies and Community Health Agents, in addition to those included in outpatient, emergency and hospital care, and it is essential to define referral mechanisms between these services, because the study shows the need for these links between the network to solve common problems regarding the victims of violence.⁸⁻²¹

It was evidenced that one nurse did not understand how to perform the identification of a victim and another nurse who limits himself to a clinical sign to evidence violence, according to reports:

[...] physical exam and data collection, ne? (E8)

[...] physical aggression. (E4)

It was shown, by the professionals, the non-perception of the importance of observing clinical signs, symptoms or the thorough performance of physical examination or anamnesis, with qualified listening. It is pointed out that the health area is a pioneer field for the identification of violence, and when the nurse does not perceive the importance of identification, he/she contributes to the invisibility of the phenomenon and the possible loss of the right to life. The study points out that the nurses' assistance must be based on knowledge, thus, the professional must have skills to be able to detect possible cases of violence in order not to let them go unnoticed.²⁰

The reports contradict the precepts defined by the Ministry of Health, since the nurse must be qualified to apply the Manchester protocol in which he/she must perform the welcoming service and qualified listening.

Most common type of violence from the point of view of Nurses

The nurses were asked how to identify the most common types of violence in care, because, according to the national policy to reduce morbidity and mortality from accidents and violence, professionals should be able to identify the types of violence, contributing to its reduction, epidemiological surveillance, prevention and promotion, prioritizing violence against women, children, adolescents, the elderly, the disabled and workers, and violence against women was the most reported in the interview. It is observed that, in a total of 16 interviewees, 11 referred violence against women as the most frequent, evinced by the following reports:

[...] aggression, ranging from couples to street fights, most of them domestic. (E2)

[...] women are also victims of aggression, where the majority are in fact against women. (E1)

[...] domestic violence with women, aggression even. (E3)

[...] violence against women. (E6)

It was noted, by the notes raised by the interviewees, the growing demand for domestic violence in urgency and emergency services and, in this context, it is reported the importance of sensitized and trained professionals to identify these victims and treat patients who present symptoms that

may be related to abuse and aggression, thus, enabling a comprehensive and quality care, especially in cases of domestic violence, in which there must be ability to handle these situations, such as conducting an improved physical examination, as well as qualified listening during anamnesis.

The study highlights the importance of using the Manchester protocol for women victims of violence, since it is relevant for classification, listing them according to their complaints, but does not include all the specificities that these patients bring with them, since it is centered on the biomedical model, requiring nurses to use other mechanisms to fully assist women, such as qualified listening, for example.²²

It is believed, by many professionals, that domestic violence is a personal and private problem and, therefore, they have no right to meddle in this type of issue, since it is a social or legal problem, but not a Public Health problem, also thinking that women like to be beaten, otherwise, they would not stay with the aggressor. It is warned that the perceptions described above are all mistaken, which contributes to the perpetuation of violence against women, since the professional loses the opportunity to perform a qualified intervention.¹⁰

Nursing Care and the embracement of victims of violence

This category addresses all the assistance and reception provided by the nurse to the victims, analyzing whether the assistance is performed in an appropriate manner for the care and verifying whether the nurse knows how to act when faced with a victim of violence. In the places where the study was conducted, it is essential to have qualified and appropriate assistance for the care and reception, considering that, in most cases, it was noted a need to obtain more effective assistance by some professionals and, going against this, some professionals perform it in a more complete way, with no consensus on the part of the interviewees.

[...] we refer to the clinician and do the risk classification here. (E3)

Nurses stand out for their generalist characteristics, which allow them, when performing triage in the emergency sector, to take responsibility for the initial assessment of the patient, initiate the diagnosis, direct the patient to the appropriate clinical area, supervise the flow of care, have autonomy and direct the other members of the team, also being a priority a set of knowledge, attitudes, skills and abilities that enable the professional to a humanized care.¹¹⁻¹³

It is understood that one of the functions of the nurse within an emergency care unit is triage, which is an exclusive competence of the nurse, supported by the Federal Council of Nursing (COFEN), having as a concept the first care of patients, aiming at the first evaluation, allowing the professional to know what should be done from the moment, according to the risk classification,

allowing more serious patients to be prioritized immediately, however, without dismissing any patient without care.⁹

It was possible to notice, in this category, that most of the nurses perform their care properly, using the Manchester protocol, in which it was possible to notice its effectiveness in the care and the flow of the work process, as evidenced in the following report.

[...] we make the initial approach and orientation, and refer them to Social Services, this is a standard of this unit. (E18)

It is known that risk classification is a tool that, besides organizing the waiting line and proposing another order of care than the order of arrival, also aims to ensure immediate care to the user with a high degree of risk; inform the patient, who is not at immediate risk, about the likely waiting time; promote teamwork; provide better working conditions for professionals; increase user satisfaction and, especially, enable and encourage the pact and construction of internal and external networks of care. It is important to emphasize that for the use of assessment protocols with risk classification, nurses and doctors must be certified by means of training provided by the Brazilian Risk Classification Group.¹¹

It is inferred, however, that only three nurses demonstrate that the care provided to victims is performed with a lack of care evidenced by the statements below.

[...] assistance is the welcoming and reassuring of the patient. (E12)

[...] here is what it is for everyone, except that we call on Social Services in most cases. (E13)

[...] we recommend that you file a police report, communicate with the family and social services. (E14)

It is observed, in view of the reports, that there is a need to work with a health care network and the professional's knowledge about this network.²⁰ One notices, in this line of thought, a lack of care for the victim of violence and what conduct to perform in front of the victim and, by the expression E3 - *"Here is what it is for everyone, except that we trigger Social Services"* - it can be inferred that the professional is not prepared to welcome and listen, aiming at a qualified service.

A research carried out points out the importance of nurses in the urgency and emergency reception processes, as they are qualified professionals who can be responsible for it, after training.²³ However, based on the reports, one notices the negligence on the part of the nurses regarding the reception, attributing this function to another component of the multiprofessional team.

The reception with risk assessment and classification can result in a dynamic process of identification of the users' conditions that require immediate treatment, according to their risk

potential, health problems or degree of suffering, and the health professional must be trained to listen to the user's complaints, fears and expectations, humanizing the service and offering a solution to the problem presented.¹¹

Professional training for nursing management of victims of violence

The interviewees were asked about receiving training to assist victims of violence, and most of them showed a deficit in relation to continuing education in the workplace.

[...] no, the only thing I saw was during graduation. (E14)

[...] I think so, maybe, these courses that we participate in, yes. (E19)

[...] we are trained in classification and oriented to continue this type of care. (E15)

Questions of doubt were reported by some:

[...] I am not remembering well no, I have done so much training, so many things, I think so, at some point in my life, I am not remembering now precisely, but yes. (E15)

[...] I think so, maybe these courses that we participate in yes. (E19)

It is understood, in view of the reports exposed, the deficiency on the part of the management in regularizing these trainings, as can be seen in the report below.

[...] no, just the day to day in practice. (E9)

The data indicates, therefore, a failure in the implementation of the ordinance and legislation in force in this facility, however, a nurse had knowledge about the training and continuing education programs, demonstrating to be able to develop the care with victims of violence.

[...] yes, there is continuing education, which is mandatory by the city's employee's legislation, protocol updates, as well as continuing studies related to this service, such as how to assist a person who has been shot, how to assist a person who has been stabbed, types of dressings. (E11)

One of the challenges faced by ECU is not having specific legislation, however, the Ministry of Health has promulgated a series of ordinances, among which is Ordinance No. 2.048, 2002,¹² approving the Technical Regulation of State Emergency and Urgent Care Systems in Brazil, which determines that nurses must have the following general requirements: availability for the training described in Chapter VII, as well as for periodic recertification. It is also established by the ordinance that nurses have the following competence/attribution: to participate in training and improvement programs for healthcare personnel in emergencies, particularly in continuing education programs.¹³

It is believed that the fact that nurses graduate with the title of generalists does not mean that they received, in their undergraduate curriculum, content related to mobile emergency care and, moreover, the national policy of care to urgencies and emergencies is recent in Brazil. It is a

complex activity and requires special training because it deals with unpredictable situations in which knowledge interferes in the outcome of the work.¹³

It is described in Ordinance 2.048, 2002,¹² that the content taught in undergraduate courses in Nursing and Medicine are insufficient and that the professionals who will work in Mobile Pre-Hospital Care Services must be qualified by the Nucleus of Education in Emergencies. It is added that these cores have as objective to promote formation programs and continued education in the form of training according to the diagnosis of each region, to train human resources, to stimulate the creation of multiplying teams, among others.¹³ Studies point out such fragility in the process of training nurses and, thus, emphasize the importance of reformulation for a better approach to the aspects related to knowledge and conduct about assistance to victims of violence.¹⁷⁻²⁰

It is known that these services have a team of professionals from various areas, who must be trained by the Centers for Education in Emergencies, whose main objective is to promote the training and continuing education of workers for the proper care of emergencies at all levels of care. It is complemented, thus, that this teaching and learning process is not only made by the transference of technical content, norms and protocols, but, above all, it must take into account the experiences lived by individuals and their professional and personal baggage.¹⁴

The growing number of accidents and violence has generated a strong impact on the UHS and society and, as far as this impact is concerned, it can be observed and measured by the increase in hospitalization costs, assistance in Intensive Care Units and by the long hospital stay of this patient profile. In the social scope, this can be perceived by the high mortality rates from accidents and violence in the last years, thus occurring an overload in the area of emergency care.¹⁴

Perceptions on flow and referrals

The flow of patients occurs in the units in a complex manner, and we tried to understand where they were referred to (and if they were referred to) for continuity through some other specific service besides Nursing, providing continuity in the care provided, not only at the time of first contact, but also after that, where it was noted that, in most cases, they were referred to the Social Service and, if necessary, to make an Police Report (PR) and, rarely, to a hospital or competent body. We detected, due to this, the inexistence of a correct flowchart, most of the time, either because of lack of time, or because they were unaware of it, thus there were controversial answers.

[...] I can't tell, it's Social Services that knows. (E4)

[...] that's right, this part is up to the Social Services. (E9)

[...] I don't know, because it's not up to us, but, here at the ECU, I send it to Social Services.
(E10)

[...] the support part is already with the Social Service, which provides orientation and, if necessary, goes to the police station, it's all with the Social Service, here it's just risk classification. (E1)

It is noted that understanding the epidemiological characteristics of violence is the first step to define the action and expand the possibilities of prevention and, when violence is diagnosed, the professional must take action in the competent instances to reverse the situation and ensure the integrity and rights of the victim. It is trusted that the health services have the duty to welcome and support, instead of being one more obstacle for the victims. Knowledge of the services available is essential for professionals to have an adequate attitude in assisting the victims of aggression.

It should be noted that the Social Service is responsible for forwarding the notification to the Epidemiological Surveillance System, the Guardianship Council or other competent bodies. The legislation on violence in Brazil has as a reference the American model regarding the obligation to notify, the need to forward the notification to a body designated by law, and the punishment for the professional who fails to notify. However, the records are compromised due to fear of retaliation, difficulty or embarrassment to fill out the form, overload in the daily life of the service and difficulty in dealing with cases, among others.¹⁵

It is pointed out that, when the interviewees were questioned about flowchart, the speeches show that nurses are aware of referrals and flow, being the responsibility of the professional to have knowledge. It is believed that valuing the importance of notification is effective for the treatment of victims of violence and contributes to health promotion and ensures the safety of these victims.

It was identified, by the nursing professionals of ECUs, that the notification is performed by Social Services, however, it is noticeable the lack of knowledge in recognizing the victim to comply with their ethical and legal duty. Therefore, it was realized the need for the training of professionals to diagnose, recognize, and properly conduct the victims.

[...] not because it is not my competence. (E10)

[...] yeah, generally, we don't notify here because we don't have that time here, but, when it is identified, I send it to the assistant and she notifies. It is her role to do this. (E5)

[...] the support part is already with the Social Service, which gives the orientation and, if necessary, goes to the police station, it's all with the Social Service. (E1)

[...] social services that will make the proper referral. (E7)

[...] for Nursing or Social Services supervision. (E9)

The legal responsibility of the health professional regarding the filling out of the notification form is found in Federal Law No.10,788,⁷ which, in its 5th article, states: "Failure to comply with the obligations established in this Law constitutes a violation of the legislation related to public health, without prejudice to the applicable penal sanctions". By interpreting this article, it can be said that, in addition to the penal provisions, the health professional would also be subject to the penalties provided for in his professional code of practice.

It is explained that, although the Brazilian legislation is clear about the obligation to notify, it does not provide good orientation for professionals. In this sense, training and articulation among health professionals, social workers, lawyers, psychologists, education professionals, among others, are necessary for an interdisciplinary work in the prevention and combat of violence.

After receiving the victim, the health professional should fill out the Notification Form in two copies, forward them to the Social Service or to the Program of Prevention and Care for Victims of Violence (PAV) of the Health Unit, according to the legislation: Child and Adolescent Statute (Law No. 8,069); Notification of Violence against Women (Law No. 10,778) and Elderly Statute (Federal Law No. 10,741).¹³⁻⁵

In this way, the importance of a trained nursing team to act in cases of violence is emphasized for the provision of humanized and reliable assistance, guided by the light of nursing professionalism, so that the victims may have their demands met in the biopsychosocial aspect. Therefore, the issues related to conduct in cases of violence, as well as the precepts of holistic care, should be widely discussed from the training courses of the nursing staff, either in the technical sphere or in Higher Education.

CONCLUSION

The study proved to be of fundamental importance to add knowledge to researchers, understanding the functioning of urgency and emergency care for victims of violence, analyzing the knowledge and practices of nurses working in ECUs. However, several gaps were identified with regard to a qualified care, which can be shallow, making this something harmful during the assistance to the victim of violence.

It was noted that some nurses have no difficulties in recognizing the victims of violence, especially in the risk classification, however, some had notes of doubt and was reported, by them, the violence that occurs more frequently, which are the cases of violence against women.

The assistance provided is fundamental, highlighting the triage with risk classification based on the Manchester protocol. However, it is necessary to pay attention to the step regarding the reception, where it was found that some nurses do not perform it properly, since it is necessary a qualified listening, always aiming at the individuality of each patient.

It was observed, through reports, due to the lack of specific training, in most of the interviewees, that continuing education is not carried out as recommended in the instructive manual of the Urgent Care and Emergency Network in the Unified Health System (UHS) and, furthermore, the lack of knowledge of the referrals and flow for the victim of violence leads to damage, trauma, suffering and costs for people and health systems.

The study's limitations include the approach to knowledge and practices towards victims of violence in general, not being possible to detail the specifications by age groups and publics, due to the breadth of the line followed by this study, being necessary to carry out more delimited studies for such. However, it is believed that this research contributes to the advancement of nursing knowledge from the dissemination of the potentialities and gaps identified. It is also hoped that this study can serve as a reflection for nurses about their care practices towards victims of violence, so that they can develop greater autonomy to face and manage cases within the scope of care.

CONTRIBUTIONS

All authors contributed to the conception of this article, data collection, analysis and discussion, as well as writing and critical review of the content with intellectual contribution and approval of the final version of the study.

CONFLICT OF INTERESTS

Nothing to declare.

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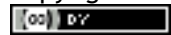
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