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Midwifery Care For Maternity In Ny.S Age of 29 Years 39 Weeks Of Pregnancy G3 P2 A0 With Ambiances Early Rupture (Kpd) At Al-Fitrah Pratama Clinic Tanjung Temple

Tri Suci Dewi Wati[1],Miranti[2]

Midwifery Study Program, STIKes Putra Abadi Langkat

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ABSTRACT

Premature rupture of membranes is still a health problem in Indonesia with a high incidence and mortality rate.According to WHO, the incidence of premature rupture of membranes (PROM) ranges from 5-10% of all births. Preterm PROM occurs in 1% of all pregnancies and 70% of cases of PROM occur in term pregnancies. In 30% of cases PROM is the cause of premature birth. The incidence of PROM in Indonesia ranges from 4.5-7.6% of all pregnancies. Able to increase knowledge, skills, and experiencewhich is evident in providing midwifery care to Mrs. SG3 P2 A0 at PMB Sri Kurniawati AM.Keb with premature rupture of membranes in 7 steps Varney. Descriptive observational is a case study approach. Descriptive research method is a research method carried out with the main aim of making an objective picture of a situation.After providing midwifery care to Mrs. S, the results of midwifery care were: general condition was good, consciousness: composting, Vital Signs BP: 110/80 mmHg, Pols: 80 x/i, RR: 24 x/i. Temp: 36□C. Bleeding: none, empty bladder, TFU: 1 finger below center. There was no maternal infection, delivery was normal, mother and child survived. There was no gap between theory and practice in the midwifery care provided to Mrs. S.

E-mail:

trisucidewi@gmail.com, miranti24@gmail.com

1. Intoduction

The contribution of maternal and child mortality rates in Indonesia is quite large, namely maternal deaths of 390/100,000 deliveries and perinatal deaths of around 400/100,000 live births, an estimated 5,000,000 people giving birth per year. Maternal deaths are around 165,000-170,000 people/year or occur about every 2.0-2.5 minutes. Perinatal mortality is 400/100,000 people or about 200,000 people per year so that perinatal deaths occur every 1.2-1.5 minutes. (Manuaba, 2010)

The causes of Maternal Mortality Rate (MMR) in Indonesia are bleeding 25%, eclampsia 12%, unsafe abortion 13%, prolonged labor 17%, infection 13% and others 20%. Infection is the third cause of high AKI. The cause of infection is due to processes that are passed during pregnancy and childbirth such as KPD 65%, febrile 17%, amnionitis 0.5-1.5%, urinary tract infections 15%. PROM is the first order cause of AKI. (Supartini, 2011 quoted from Nia Aprilia, 2017)

According to WHO, the incidence of premature rupture of membranes (PROM) ranges from 5-10% of all births. Preterm PROM occurs in 1% of all pregnancies and 70% of cases of PROM occur in term pregnancies. In 30% of cases PROM is the cause of premature birth. The incidence of PROM in Indonesia ranges from 4.5-7.6% of all pregnancies, while in India the incidence of PROM is between 6-12%. This figure is an unresolved problem, especially in developing countries. (Ministry of Health RI, 2015)

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Premature rupture of membranes (PROM) is defined as rupture of the membranes before there are signs of labor starting and waiting for one hour before the start of labor. The time from the rupture of membranes to the onset of uterine contractions is called the "premature rupture of membranes" the latent period. Most mothers who experience premature rupture of membranes are those who are pregnant at term above 37 weeks, while less than 36 weeks are not too many (Manuaba, 2010).

Management of midwifery care in cases of PROM is very important considering the complications that can be caused by PROM are very serious. In general, PROM management is carried out according to gestational age, at term gestational age or > 37 weeks induction can be carried out, the aim is to reduce the possibility of maternal death due to infection. If the gestational age is <37 weeks, treatment is carried out in a hospital to delay delivery and give corticosteroids to achieve lung maturity (Saiffudin, 2009).

From a survey conducted at the Al-fitra Primary Clinic, Tanjung Pura from January 1 to December 2019, it was found that 130 mothers gave birth normally and 60 mothers gave birth pathology, including 24 mothers who gave birth with laceration of the birth canal, 13 mothers who gave birth with premature rupture of membranes, 7 mothers gave birth with retained placenta, 3 women gave birth with shoulder dystocia, 3 women gave birth with preeclampsia. And from January to April 2020, 24 women gave birth normally and 12 women gave birth pathologically, including 4 women who gave birth with premature rupture of membranes, 2 women who gave birth with laceration birth canal, 3 women gave birth with retained placenta, and 3 women gave birth with preeclampsia.

Seeing that there are still occurrences of premature rupture of membranes, the authors are interested in conducting a case study care with the title "Midwifery Care for Maternity Mothers with Premature Rupture of Membranes at the Al-fitra Primary Clinic Tanjung Pura" by using a midwifery care approach according to Varney's 7 steps.

2. Research methods

2.1 Data collection

In this step the midwife collects all accurate and complete information from all sources related to the client's condition. (Varney, 2010)

1. Subjective data
   Subjective data is an accurate source of information, also called primary data source. Data obtained from family members or from other health workers is also called secondary data source. There are 3 data collection techniques, namely observation, interview, and examination. In the case of premature rupture of membranes, subjective data obtained in the form of discharge in the form of water from the vagina dripping or seeping before the labor process took place in primie less than 3 cm and in multiparas less than 5 cm and can occur in pregnancy >37 weeks, this fluid will not stop or dry because it continues to be produced until birth. Fever, vaginal spotting a lot, abdominal pain, fetal heart rate is accelerating are signs of an infection that occurs. (AnikMaryunani, 2016)
2. Objective Data
   In the case of mothers hearing premature rupture of membranes, the data can be obtained from an examination carried out directly by the midwife. According to Sarwono (2016), the way to assess that the fluid that comes out is amniotic fluid is by looking at the presence of amniotic fluid in the vagina, if not there can be tried. with slight movements of the lower part of the fetus or asking the patient to cough or strain, determine gestational age, determine the presence or absence of infection, and determine signs of labor such as internal examination and regular contractions.

2.2 Formulate midwifery problems/problems

In this step the identification of a diagnosis or problem is based on an accurate interpretation of the data that has been collected. The basic data that has been collected is interpreted so that it can formulate a specific diagnosis and problem. requires handling. Problems are often related to things that are being experienced by the woman identified by the midwife according to the results of the assessment. Problems also often accompany the diagnosis.(Saminem, 2009)

A midwifery diagnosis is a diagnosis made by a midwife within the scope of midwifery practice and meets the standards of the midwifery diagnostic nomenclature. In the case of amniotic fluid leaking from the vagina, the amniotic fluid smells fishy and does not smell like ammonia, this fluid will not stop or dry because it continues to be produced until birth, and there are signs of parturition. blue-base properties, blood leukocyte esterase (LEA) test, amniotic fluid Fern test, ultrasound examination (helps in determining the amount of amniotic fluid and gestational age, fetal abnormalities).

2.3 Develop a comprehensive plan of care

In this step, a comprehensive care plan is determined by the previous steps. This step is a continuation of the management of problems or diagnoses that have been identified or anticipated, either immediate or routine. At this step incomplete data information can be supplemented by formulating actions that are evaluating / re-examining or needing follow-up actions. A comprehensive care plan does not only include handling problems that have been identified from the client's condition or from any related problems, but also actions that take the form of anticipation (needs counseling and counseling). (Atik Purwandari, 2008)

2.4 Implementation/implementation

In this sixth step, the comprehensive care plan as described in step 5 is implemented efficiently, effectively, and safely. This implementation is carried out entirely by the midwife or partly by the client or other members of the health team. Although the midwife does not do it herself, she still bears the responsibility to direct its implementation. In situations where the midwife collaborates with the doctor to treat a client with complications, the midwife is responsible for managing the client's care according to a comprehensive joint care plan. Its efficient management will involve time and cost and improve quality and client care. Review whether all the care plans have been implemented (Atik Purwandari, 2008).

3. Results and Discussion

In this chapter the author will describe the case that has been taken about the gaps that occur in practice carried out in the field with existing theory, using Varney's 7-step midwifery management approach, from assessment to evaluation. The discussion is intended so that conclusions can be drawn and problem solving gaps that occur so that they can be used as a follow-up in the implementation of effective and efficient midwifery care, especially in maternal patients with premature rupture of membranes.

3.1 Assessment

According to Anik Maryunani, 2013 that premature rupture of membranes is the discharge of fluid in the form of water from the vagina after 22 weeks of pregnancy before labor takes place and can occur in preterm pregnancies before 37 weeks of pregnancy or term pregnancy.

In the case of Mrs. From the data obtained, there are similarities in the symptoms contained in the theoretical review, namely vaginal discharge: cloudy white fluid and a characteristic odor, VT results: the state of the birth canal is elastic with an opening of 2 cm amniotic fluid: ruptured with vaginal discharge and is clear in color. carried out by Yeni Ana Pratiwi with the title Midwifery Care for Mrs. E Age 29 years of gestation 39 weeks G1P0A0 with premature rupture of membranes at Siti Khalijah Medan Marelan 2017. So it can be concluded that there is no gap between theory and practice.

3.2 Interpretation

According to Varney (1997) in the data interpretation step, the midwife analyzes the subject and object data obtained in the first step accurately and logically so that the midwife can formulate diagnoses and problems.

According toSaminem (2009), a midwifery diagnosis is a diagnosis made by a midwife within the scope of midwifery practice and meets the standards of the midwifery diagnostic nomenclature.The basic data that have been collected and interpreted so that they can formulate the problem are both used because the problem cannot be defined as a diagnosis but still requires treatment.

In the case of maternity mothers, Mrs. S G3P2A0 aged 29 years, the subject data obtained are: third pregnancy, never had an abortion, the mother's main complaint is discharge that seeps through the vagina, the mother has had heartburn since 03.00 WIB, pain in the lower abdomen that radiates

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to the waist and HPHT: 05 -06-2019. And the objective data are: KU: good, TTV: BP: 120/80 mmHg, Pols: 80 x/i, RR: 24 x/i, T: 36ºC, TFU: 33 cm, contractions: 3 x 10 minutes duration 30 seconds , percentage: head, Pu-Ka, FHR: 144 x/i regular, punctum maximum right lower central quadrant, TBBJ: (33-11) x 155= 3,410 gr, vaginal examination: leaking amniotic fluid, clear color and characteristic fishy odor amniotic sac, VT: elastic birth canal, 2 cm amniotic opening (+). So the nomenclature is G3P2A0 UK 39 weeks 4 days, single live fetus, Pu-Ka, head percentage,

3.3 Potential Diagnosis

A potential diagnosis is a statement about a problem that is expected to occur and requires additional data. According to Anik Maryunani (2013) diagnoses that may occur in the mother are maternal infection, preterm delivery, oligohydramnios, dry parturition, intrapartum infection, uterine atony, endometrial, and can occur septic shock to maternal death. And the potential that can occur in the fetus is fetal distress, asphyxia, perinatal sepsis, trauma at birth, and prematurity.

On Mrs. S aged 29 years, no problems were found so that a potential diagnosis was not established and did not require more intensive treatment. In accordance with the results of research conducted by Yeni Ana Pratiwi with the title Midwifery Care for Maternity Mothers, Mrs. E, 29 Years of Gestational Age 39 Weeks G1P0A0 with Premature Ruptured Membranes at Siti Khalijah Medan Marelan 2017.

3.4 Immediate Action

Immediate action is taken if a potential diagnosis is found with the aim of anticipating problems that may arise in connection with the problems experienced. According to Sarwono (2009), treatment for premature rupture of membranes can be done conservatively or actively, namely: giving a fluid infusion of physiological saline solution, 5-10% glucose solution, induction. (Sarwono, 2010)

In the case of maternity mothers, Mrs. S aged 29 years G3P2A0 at the Tanjung Pura Al-Fitrah Clinic with premature rupture of membranes, the midwife took immediate action, namely monitoring the delivery process according to the APN 58 steps.

From the results of the implementation carried out on Ny. S aged 29 years G3P2A0 at the Al-Fitrah Clinic Tanjung Pura there is a difference between theory and practice carried out in the field in planning. This can occur due to the experience and knowledge of the midwives at the Al-Fitrah Tanjung Pura Clinic who have been doing MCH services for a long time

3.5 Action plan

According to Atik Purwandari (2008) a comprehensive plan of care does not only include handling problems that have been identified from the client's condition or from any related problems, but also actions that take the form of anticipation (needs counseling and counseling).

Midwifery care plan for premature rupture of membranes according to (Sarwono, 2010):

a. Pregnancy >37 weeks, induction with oxytocin, if cesarean section fails. Misoprostol 50 g intravaginally every 6 hours can also be given up to 4 times.
b. If there are signs of infection give high doses of antibiotics, and labor is terminated:
    - If the pelvic score is < 5, observe the cervix, then induction. If it doesn't work, end the labor by cesarean section
    - If pelvic score > 5, induction of labor, vaginal delivery

The action plan in the case of pregnant women, Mrs. S with premature rupture of membranes are:

1. Inform the results of the examination to the mother and family
2. Do informed consent
3. Observation of FHR, Pols, His, every 30 minutes and Observation of cervical dilatation, decrease in head, temperature, BP, and urine every 4 hours.
4. Advise the mother to choose a comfortable position, lying on the left/right side
5. Teach the mother relaxation techniques, especially when there is hysteria
6. Advise mother to urinate
7. Feeding the mother and drinking between contractions
8. Teach mom how to push the right way
9. Advise the mother to choose a birth attendant
10. Prepare tools and materials for delivery according to APN
11. Carry out normal delivery care actions 58 steps

12. Document the results of the first stage and fourth stage observations on the partograph sheet

In carrying out an action plan for midwifery care in the case of Mrs. S aged 29 years G3P2A0 at the Al-Fitrah Clinic Tanjung Pura, there is a difference between theory and practice in the field. This is because during partograph monitoring there were no problems that required emergency or immediate action to save the lives of the mother and baby.

3.6 Implementation

This implementation is carried out entirely by the midwife or partly by the client or other members of the health team. Although the midwife does not do it herself, she still bears the responsibility to direct its implementation.

In situations where the midwife collaborates with the doctor to treat a client who is experiencing complications, the midwife is always responsible for managing the client's care according to a comprehensive joint care plan. Its efficient management will involve time and cost and improve quality and client care. Review whether all care plans have been implemented. (Atik Purwandari, 2008)

In the review that has been carried out in accordance with the action plan, in the case of Mrs. S aged 29 years with premature rupture of membranes, the implementation was in accordance with the planned care to provide delivery assistance in accordance with the APN 58 steps. Basically the implementation procedure in practice is different from theory but there are additions that are tailored to the patient's needs.

3.7 Evaluation

According to Atik Purwandari (2008), an evaluation of the effectiveness of the care that has been provided, includes whether the fulfillment of needs has been met according to the diagnosis and problem. A plan is considered effective if it is truly effective in its implementation.

It is possible that some of these plans are effective while some of them have not been. The process of implementing this care is a continuous activity so it is necessary to repeat any ineffective care and make adjustments to the plan.

To find out the success of the care that has been given to the patient at this step, the author did not find a gap between the theory and the case in the field. Evaluation or results of the care that has been given in accordance with the expected results.

In this case the author can carry out midwifery care for maternity mothers on Ny. S with premature rupture of membranes (KPD) which was carried out at the Al-Fitrah Tanjung Pura Clinic and no emergency was found. The results of midwifery care were: General Condition: Good, Awareness: Composmentary, Vital Signs BP: 110/80 mmHg, Pols: 80 x/i, RR: 24 x/i, Temp: 36ºC. Bleeding: None, Bladder: empty, TFU: 1 finger below center. There was no maternal infection, delivery was normal, mother and child survived. KPD action is carried out properly and quickly in a comprehensive manner.

4. Conclusion

In this case the author can carry out midwifery care for maternity mothers on Ny. S with premature rupture of membranes (KPD) which was carried out at the Tanjung Pura Al-Fitrah Clinic and no emergency was found. With the results of midwifery care, namely: General Condition: Good, Consciousness: Composmentris, Vital Signs BP: 110/80 mmHg, Pols: 80 x/i, RR: 24 x/i, Temp: 36ºC. Bleeding: None, Bladder: empty, TFU: 1 finger below center. There was no maternal infection, delivery was normal, mother and child survived. KPD action is carried out properly and quickly in a comprehensive manner.

Reference

Aprilla, Nia. (2018). Risk Factors for Maternity Who Experienced Premature Rupture of Membranes at Bangkang Hospital in 2017. Journal of Public Health. 2623-1581.

Indonesian Ministry of Health. (2015). Indonesia Health Profile 2014. Jakarta: Ministry of Health RI

Manuaba, IBG (2010). Obstetrics and Gynecology Emergency and Social Gynecology Obstetrics for the Midwife Profession. Jakarta: EGC.

Maryunani, Anik. (2016). Pathological Pregnancy and Delivery (High Risk and Complications) in Obstetrics. Jakarta : CV Trans Info Media.

Contents lists available at IOCScience

Science Midwifery

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Mochtar, Rustam. (2013). Synopsis Obstetrics Physiology Obstetrics Pathology Volume 3. Jakarta: EGC.

Mutmainnah, Annisa UI, et al. (2017). Maternity and Newborn Care. Yogyakarta: ANDI.

Prawirohardjo, Sarwono. (2016). Midwifery. Jakarta: Sarwono Bina Pustaka Foundation.

Purwandari, Atik. (2014). The Concept of Midwifery History and Professionalism. Jakarta: EGC

Saminem, Hj. (2009). Normal Pregnancy. Jakarta: EGC.

Sofyan, Mustika, et al. 2006. 50 Years of the Indonesian Midwives Association Welcoming the Future. Jakarta: PPIBI.

Varney, H. (2008). Midwifery Teaching Textbook Edition 4 Volume 2. Jakarta: EGC

Wildan, M. (2011). Midwifery Documentation. Jakarta: Salemba Medika.