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Midwifery Care for Pregnant Women Ny.E G1p0a0 With Placenta Previa at Al-Firah Maternity Clinic Tanjung Pura Using Midwifery Management Approach According to Varney in 2019

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ABSTRACT

Based on the results of the 2015 Inter-Census Population Survey (SUPAS), the MMR in Indonesia again showed a decline to 305/100,000 live births. The causes of maternal death in Indonesia include placenta previa, namely 2.77% in 2015 and 0.85% of them died. Type of case study report with descriptive method, location at Al-Fitrah Maternity Clinic Tanjung Pura. Data collection techniques include primary data including physical examination, interviews and observation and secondary data, including documentation studies and literature studies. Able to carry out midwifery care for pregnant women with placenta previa using Varney's 7-step midwifery approach. For midwifery care for pregnant women at the Al-Fitrah Maternity Clinic Tanjung Pura, after carrying out midwifery care for 3 days, the results were: Bleeding stopped, there are no contractions and the general condition of the mother and fetus is good. There is no gap between theory and practice so a potential diagnosis of hypopolemic shock does not occur. The results of midwifery care carried out for 3 days the mother came home in good condition and there was no bleeding.
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1. Introduction

According to the World Health Organization (WHO), maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause, regardless of the duration of the pregnancy and the actions taken to terminate the pregnancy.(La Banto, 2016).

MMR is the main indicator in determining the degree of public health. Starting in 2016, the sustainable development goals (SDG's) 2015-2030 officially replaced the Millennium Development Goals (MDG's) 2000-2015. Judging from the time, high AKI occurs during pregnancy, childbirth and the puerperium, most of these deaths are caused by bleeding and infection. In the third goal of SDG's: good health (National Health System) guarantees a healthy life and promotes well-being for all people at all ages. One of the targets of the SDGs by 2030 is to reduce maternal mortality to below 70 per 100,000 live births(Ruqoiyah, 2017).

Based on data from the World Health Organization (WHO) in 2015 the Maternal Mortality Rate (MMR) worldwide was estimated at 216/100,000 live births and the neonatal mortality rate fell by 47% between 1990-2015, from 36/1000 live births to 19/1000 births. alive in 2015. The success of maternal health efforts can be seen from the indicators of the Maternal Mortality Rate (MMR). This indicator is not only able to assess maternal health programs, it is also able to assess the health status of the community. Based on the results of the 2015 Inter-Census Population Survey (SUPAS), the MMR in Indonesia again showed a decline to 305/100,000 live births. Likewise, the Infant Mortality Rate (IMR) in Indonesia also showed a decline to 22.23/1,000 live births(Riani, 2018).

The routine report of the maternal health program of the provincial health office in 2012 explains that the causes of maternal death in Indonesia are still dominated by bleeding (32%) and hypertension in pregnancy (25%), followed by infection (5%), prolonged labor (5%), and abortion

(1%). In addition to obstetric causes, maternal mortality is also caused by other causes (non-obstetrics) by 32%(Handayani & Fourianalistyawati, 2018).

Antepartum hemorrhage is the cause of maternal death determined as bleeding from the genital tract after 20 weeks of gestation and before delivery. Overall 2-5% of all pregnancies are antepartum hemorrhage. There are two causes of antepartum bleeding namely placenta previa, placental abruption and other causes.(Elisa, 2018).

Antepartum hemorrhage is an emergency case that occurs in 3% of all deliveries, the causes include placenta previa, placental solution, and bleeding of unknown source. Antepartum bleeding that occurs in the third trimester of pregnancy and that occurs after the child or placenta is born is generally an heavy bleeding. If you don't get treatment quickly, it will cause fatal shock(Kurniawan & Maulina, 2015).

Placenta previa is a pregnancy complication in which the placenta is located in the lower part of the uterus, partially or completely covering the cervix. This causes painless vaginal bleeding and some leads to bleeding. Bleeding that may be large enough to threaten the life of the mother and fetus necessitates immediate delivery, either elective or emergency(Pawa et al., 2017).

The prevalence of placenta previa in the world is estimated to be around 0.52%. The highest prevalence of placenta previa is in the Asian region, which is around 1.22%, while for the European region it is lower at 0.36%. North America 0.29% and Sub-Saharan Africa 0.27% (Cresswell et al., 2013). The prevalence of placenta previa in Indonesia in 2015 was 2.77% and 0.85% of them died (Kemenkes RI, 2007). The incidence of placenta previa in Sumatra in 2010 was 106 based on hospital information system data(Suspimantari & Pramono, 2014).

Placenta previa is caused by the implantation of a blastocyst located low in the uterine cavity. Factors that influence the occurrence of placenta previa are increased maternal parity, increased maternal age, enlarged placenta due to multiple pregnancies, damage to the endometrium such as previous dilatation and curettage, history of previous cesarean section, uterine scars and myomectomy or endometritis, history of placenta previa, and smoking habits(Hartuti, 2018).

The number of pregnant women who experienced placenta previa at the Al-Fitrah Clinic from January 2018 - October 2018 was 7 cases. These data indicate that the incidence of placenta previa is still quite high.

2. Method

2.1 Case Study Type

The method used in this case study is descriptive method. That is a method that is carried out with the main objective of describing or making an overview of the situation objectively and this type of report is a case study, which is carried out by examining a problem through a process consisting of a single unit..

2.2 Case Study Time and Location

The time of the implementation of this case study was on July 18 – July 21, 2019 and the location where the case was taken was at the Al-Fitrah Langkat maternity clinic.

2.3 Data collection technique

In the preparation of this study, various data collections were used, including primary data and secondary data, as follows:

Primary data is data obtained or collected directly in the field by the person conducting the research or concerned who needs it (Notoatmodjo, 2010). Primary data can be obtained from: Physical Examination, Interviews conducted on Mrs. E and his family, as well as observations by making direct observations of patients to find out the progress and treatment carried out. Secondary Data is data obtained other than examination or therapy obtained from information from family, environment, studying patient status and documentation, notes in midwifery and studies (Notoatmodjo , 2010). Secondary data were obtained from: literature and documentation using data from medical records and nursing data to facilitate information on medical data at the Al-Fitrah maternity clinic, Tanjung Pura..

2.4 Research Location and Time

The location of the research is the place where the research is carried out (Muhammad, 2016) The location of this study was carried out at the Hugo Hasena Tanjung Pura Clinic, Langkat Regency. Research time refers to the period of research implementation. The time of this research is planned from January to May 2019.

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3. Results and Discussion

3.1 Identity

Name	Mrs. E		Name	Mr. R	
age	34 Years		age	35 years old	
Ethnic group	Java		Ethnic group	Java	
Nationality	Indonesia		Nationality	Indonesia	
Religion	Islam		Religion	Islam	
Education	SENIORS SCHOOL	HIGH	Education	SENIORS SCHOOL	HIGH
Work	IRT		Work	Self-employed	
Home address	Tj Pura		Home address	Tj Pura	

3.2 History

At the date of : 18- 07 – 2019 O'clock : 11.00 WIB

a. Reason for Visit :£ First £ Regular £ Irregular

b. Complaint : The mother said that she was bleeding not much fresh red, watery from the birth canal at 09.00 WIB without abdominal pain and the mother said she still felt fetal movement, the mother was worried about her pregnancy.

c. Menstrual History

First Menstruation : Age 13 years oldRegular £ Irregular
Cycle : 28 day Duration: 7 days
Amount : 3 x change dock
Blood Nature :Dilute £ Thick
Dysmenorrhea : £ There None

d. Past Pregnancy and Childbirth History

No	date Born	Gesta-tional Age	Type Labor	The place Labor	Complica-tions		Hel per	Baby		postpartum	
	age				Mot her	Baby		PB/BBT ype	state an	state	Lac-tasia
1	H	A	m	i	l		i	N	i		

e. Pregnancy History :
HPHT : Mom said the first day of her last period was on December 18, 2018
TTP : Mother said the baby's due dateSeptember 25, 2019
ANC : Mom says check2 times in midwife
. Gestational Age : Mom said she was 30 weeks pregnant
TT Immunization: Mother said that she had TT immunization when she was about to ge married, while at the time of pregnancy, the mother had also been immunized for TT twice Drugs thatconsumed : Mother said that she took the medicine given by the midwife, such as medicine add blood

f. Complaints on
First trimester : nausea and vomiting
2nd trimester : there isn't any
Third Trimester : Not much blood, not accompanied by pain
Worries : Mom saidworried abouta state of her pregnancy, because bleeding from the birth canal
First Fetal Movement :16 weeks pregnant

g. If movement is felt, the child's movements in the last 24 hours:
£ < 10 x 10x – 20x £ > 20x

h. If more than 20 times in 24 hours, with frequency:
£ < 15 minutes £ > 15 minutes

i. Complaints - complaints that are felt (if any explain)
Fatigue : Yes, during activity

Prolonged nausea and vomiting : There isn't any
Stomach pain : There isn't any
Hot, shivering : There isn't any
Headache : There isn't any
Blurred vision : There isn't any
Pain or burning during urination : There isn't any
Itching of the vulva, vagina and surrounding areas : There isn't any
Vaginal discharge : There is not much blood
Reddish pain, tension in the legs : There isn't any
Edema : There isn't any

j. Dietary habit :
Before pregnancy: Mother said to eat rice, vegetables, side dishes 3 times a day with moderate portions, mother drink 6-7 glasses a day with water, mother say there are no taboo foods
During pregnancy: Mother said to consume rice, side dishes 4-5 times a day with small portions but frequent. Mother drinks 8-9 glasses a day with water, 1 cup pregnant women's milk, the mother said there were no taboo foods.

k. Elimination pattern :
• CHAPTER • BAK
Before pregnancy : 1 x a day Before pregnancy : 3 times a day
After pregnancy : 1 x a day After pregnancy : 5 times a day

l. Daily activities

m. Rest and Sleep Pattern :
Evening : 21.30 wib to 05.30 wib
Complaint : £ There None
Afternoon : 13.30 wib to 14.30 wib
Complaint : £ There None
Work : IRT activity

n. Sexuality : According to the needs
Complaint : There isn't any

o. Contraceptives ever used: None

p. History of systemic disease
Heart : There isn't any
Kidney : There isn't any
Asthma/pulmonary TB : There isn't any
Hepatitis : There isn't any
DM : There isn't any
Epilepsy : There isn't any
Etc : There isn't any

q. Family history of illness
Heart : There isn't any
Hypertension : There isn't any
DM : There isn't any

r. Social History
Marriage
Marry I : 2018
duration : - year someone's child
Pregnancy :Planned £None
Planned :Received £None
Feelings about this pregnancy : Happy

3.3 Physical Examination (Objective Data)

a. Emotional status : Stable

b. Vital sign
Blood pressure : 100/70 mmHg BB beforepregnant: 55 kg
Pulse : 80 x/i BB now : 64 kg
Body temperature : 36,5 oC TB :154 cm
RR : 24 x/i LILA : 24,5 cm

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c. Systematic/physical examination
Head and face
Hair : Black, long, fine, no easy to fall off,clean no there is dandruff.
Advance : Not there is chloasma gravidarum, not pale, no edema, expression tense and worried face.
Eye : Symmetrical, pink conjunctiva, white sclera, noneedema.
Nose : Clean, no polyps, shape normal, no abnormalities.
Ears: Symmetrical shape,clean, no serumen, nothingabnormality.
mouth/ teeth/Gums : Lips pale, tongue pale, caries dentis not there, stomatitis is not
Yes, the gums do not bleed and are not swollen.
Neck : No gland enlargementthyroid and lymph and no lumps/ tumors in the neck.

d. Chest and Axilla
Mammae
Enlarge : Yes, normal
Tumor : No palpable lump
Symmetrical : Symmetrical right and left
Areola : Hyperpigmentation
Nipplesmilk : stand out
Colostrum : go out

e. Axilla
Tumor : No palpable lump
Painful : No tenderness

f. Extremities
Hand : No edema, symmetrical, short nails, clean, nothere is an abnormality
Foot : Symmetrical, short nails, clean, no limbs oedema, no varices, no abnormality

g. Abdomen
Enlargement : According to Gestational Age
striae : There isn't any
Form : Symmetrical
Linea : Nigra
Surgical scars : £ There None

h. Palpation
Leopold I : TFU mid-process Xyphoideus and center(28cm), fundus palpable soft round and not bouncy (buttocks)
Leopold II : left teraba hard elongated like a board (back). Left full of small parts of the fetus
Leopold III : Palpable round, hard bouncy (fetal head)
Leopold IV : The lowest part of the fetus has not enteredPAP (convergent)

i. Auscultation:
DJJ : Punctum maximum left below center
Frequency : 140x/i
Regular/not : regular

j. Pelvic
Spinarum dystonia : 26 cm
Cristarum dystonia : 31 cm
External distance : 20 cm
Hip Circumference : 89 cm

k. External Genetalia Tool
Varices : £ There None
Enlargement of the Bartholin's glands : £ There None
Vistula : There isn't any
Wound : There isn't any

Surgical scars : £ There None
VT : Not done VT butinspected by inspector and there is blood
PPV : Discharge of blood with a small amount

3.4 Diagnostic Test

Laboratory examination
Hb : 12 gr%
Urine Protein : negative
Urine Glucose : negative
Plano test : Positive
ultrasound : The results of the examination on July 18, 2019 at 8.00 WIB were a single intrauterine fetus, the placenta was visible beside blocking the roadborn (marginal)

Table 3.
Progress Data

11.00 on July 19, 2019			
S	**O**	**A**	**P**
1. Mom says feel the fetal movement 2. Mom said the bleeding is a little less 3. Mom said it's not too weak 4. Mom said she still feels anxious because the bleeding hasn't stopped 5. Mother said that she had just changed her sanitary napkins and had kept the genitals clean with a wipe from front to back and then dried with a clean towel. 6. Mom said that she was still completely resting and still urinating and defecating in bed 7. Mother said that she had taken the medicine given by the midwife, namely SF and Mefenamic acid	1. General Condition: Good 2. vital signs: BP : 110/80 mmHg RR :20 x/i Pols :80 x/i Temperature : 36.5 o C 3. Palpation: - Leopold I : Buttocks, TFU: 28 cm - Leopold II: Left Back - Leopold III: Chief - Leopold IV: Not Enrolled in PAP (Convergent) 4. PPV ; there is not much blood loss that is 15 cc 5. Extremities: 20 drops of RL infusion is still attached to the left hand 6. DJJ :142x/i 7. Contraction: None	Mrs. E G1 P0 A0 34 years pregnant 30 weeks 1 day, single fetus, alive, right back, cephalic presentation, fetal bottom has not entered PAP with marginal placenta previa .	1. Monitor the mother's general condition and vital signs every 4 hours 2. Monitor FHR and bleeding every 2 hours 3. Advise the mother to consume nutritious food and not to restrict any food so that the mother's condition recovers quickly and the fetus's nutrition is met 4. Advise the mother to maintain personal hygiene, especially on the genitals by wiping from front to back every defecation or urination 5. Continuing doctor's therapy - Infusion RL 20 tpm - Ferrous Sulphate 60 mg 2 x 1 - Mefenamic acid 500 mg 3x1 tablet - Astranek injection 500 mg/iv every 8 hours - Profecom/iv 24 hours
5:00 p.m. on July 20, 2019			
S	**O**	**A**	**P**
1. Mom says feel the fetal movement 2. Mother said that there was no bleeding from the birth canal 3. Mother said it was not weak 4. Mom said not to worry because it stopped slowly 5. Mother said that she had urinated and defecated in the bathroom 6. Mother said she was still taking the medicine given by the midwife, namely SF and Mefenamic acid 7. Mom said there were no other complaints	1. General Condition: Good 2. vital signs: BP : 110/80 mmHg RR :20 x/i Pols :80 x/i Temperature : 36.5 o C 3. Palpation: - Leopold I : Buttocks, TFU: 28 cm - Leopold II: Left Back - Leopold III: Chief	Mrs. E G1 P0 A0 34 years 30 weeks 2 days pregnant, single fetus, alive, right back, cephalic presentation, fetal bottom has not entered PAP with marginal placenta previa	1. Provide an explanation to the mother about the results of her pregnancy examination 2. Advise mother to get enough rest 3. Advise mother not to do heavy work 4. Encourage mothers to continue to consume nutritious foods 5. Doing aff infusion 6. The patient is allowed to go home and oral drug therapy is continued, including:

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3. Mom said she wanted to go home	- Leopold IV: Not Enrolled in PAP (Convergent) 4. PPV: no bleeding 5. Extremities: 20 drops of RL infusion is still attached to the left hand 6. DJJ :142x/i 7. Contraction: None		- Mefenamic Acid 500 mg : 3 x1 20 tablets - SF 60 mg : 1 x 1 10 capsules 7. Tell the mother and family if there is bleeding as soon as possible to be taken to the clinic to avoid an emergency 8. Advise the mother for control in 1 week or if there are complaints

3.3 Discussion

In this discussion, the author will explain the gap between practice and theory. Here the author will explain the gap according to the steps in midwifery management according to Varney which includes seven steps

a. Assessment

The assessment and collection of basic data which is the initial stage of obstetric management is carried out by assessing subjective data and objective data obtained by PPV that there is not much bleeding, on speculo examination it appears fresh red blood in the birth canal and the results of investigations from ultrasound show a single fetus, intra uterine, The placenta is visible beside the birth canal (marginal).

The results of the case study are in accordance with Maryuni's opinion in 2013 that the main complaint of placenta previa is bleeding without cause without pain than usually repeated blood is usually fresh red. Meanwhile, in the case of placenta previa, the supporting examinations that need to be carried out according to Nugroho (2010) are: ultrasound examination for definite diagnosis.

b. Data Interpretation

Data interpretation consists of obstetric diagnoses determining the problems and needs of pregnant women with placenta previa. In this case, the writer got the diagnosis of Mrs. E G1 P0 A0 34 years 30 weeks pregnant, single fetus, alive, right back, cephalic presentation, the lower part of the fetus has not entered PAP with marginal placenta previa with problems The mother feels anxious about her pregnancy.

The results of this case study are in accordance with Pudiastuti's opinion in 2012 for obstetric diagnosis of placenta previa, namely: Mrs.. age... years, G..P..A.. pregnant.. weeks, fetus (single/double), alive/ dead, intra/extra uterine, Puka/puki, not yet admitted to PAP with placenta previa (totalis/ marginalis/ parsalis/ low position), while the problem according to Pudiastuti's opinion in 2012 in placenta previa is that there is a disturbance of comfort and impaired activity related to bleeding. vaginally.

c. Potential Diagnosis

A potential problem is a statement that arises based on the problem that has been identified. This step requires anticipation and if possible preventive measures. In the case of Mrs. E The potential diagnosis is hypopolemic shock. This is in accordance with the opinion of Pudiastuti in 2012 which states that in the case of pregnant women with placenta previa, if the bleeding continues, it is potential for hypopolemic shock to occur.

d. Anticipation

Anticipation reflects the continuity of the midwifery management process, in the theory of anticipation, namely identifying an emergency situation where the midwife must act immediately for the interests and safety of life. In the case of Mrs. E with placenta previa anticipating the immediate action given, namely collaborating with obstetricians in providing therapy. According to Pudiastuti's opinion in 2012 which states that immediate action on placenta previa is collaboration with doctors as soon as possible if there are more severe complications with the management of antepartum bleeding and management of asphyxia in infants.

e. Planning

According to Feriyanto (2007), planning for midwifery care in Abortion Imminens patients is: total bed rest/bed rest, recommend not having sex first and collaboration with SpOG doctors. While in the case of Mrs. E pregnant with placenta previa, the planning provided is in accordance with the

opinion of Pudiastuti in 2012 namely: Explain to the mother her current condition, Observing the amount of vaginal bleeding and vital signs, Counseling on rest to the mother, Providing psychological support to the mother Counseling on nutritional and nutritional needs in pregnant women Fulfillment of fluid and nutritional needs Explain to the mother that the mother cannot carry out a normal delivery but must be by caesarean section because there is a placenta blocking the birth canal.

4 Conclusion

Based on what the authors got in the case study, the obstetric diagnosis of Ny. E G1 P0 A0 34 years 30 weeks pregnant, single fetus, alive, right back, cephalic presentation, the lower part of the fetus has not entered PAP with marginal placenta previa with Subjective Data The mother said that she had not much blood, fresh red and watery from the birth canal in at 09.00 WIB without abdominal pain and Objective Data there was not much vaginal bleeding, an inspeculo examination showed blood in the birth canal and an ultrasound examination showed marginal placenta previa. After being treated for 3 days, there was no potential for hivopolemic shock, and the placenta previa did not continue and the mother's pregnancy could still be maintained.

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