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Midwifery Care for Maternal Mother Ny: W P: 1 A: 0 With Placenta Retention at The Vivi Rahayu Am. Keb Midwifery Clinic, Kota Madya Tanjung Balai

Delimayani
Universitas Putra Abadi Langkat, Indonesian

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ABSTRACT

Maternal death or death of pregnant women is the death of a woman while pregnant, giving birth or within 42 days after giving birth (wikipedia). Meanwhile, according to Dr. Karlina Sari Maternal death is when a woman dies due to something related to pregnancy, childbirth and 42 days after giving birth Maternal death is the death of a woman during pregnancy or within 24 days after the end of the pregnancy due to any cause, regardless of the age of the pregnancy and the actions taken to end the pregnancy. According to WHO, there are several causes of maternal death, namely postnatal bleeding, high blood pressure. , complications in childbirth and unsafe abortions. Complications in childbirth that are not handled properly and on time can cause maternal death, around 15% of pregnancies/deliveries experience complications and 85% are normal, one of the complications in childbirth is retained placenta, according to the editorial article by healthy doctors, retained placenta is retained the placent is in the uterus and does not come out by itself naturally or up to 1 hour after the birth of the baby the placenta has not come out.

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Corresponding Author:

Delimayani,
D3 Kebidanan
Universitas Putra Abadi Langkat, Indonesian,
Jl. Letjen R. Soeprapto No.10, Kwala Bingai, Kec. Stabat, Kabupaten Langkat, Sumatera Utara 20814
Email: prodid3kebidananlkampusasahan@gmail.com

1. INTRODUCTION

Maternal death or maternal death is the death of a woman during pregnancy, childbirth or within 42 days after giving birth (wikipedia). Meanwhile, according to Dr. Karlina sari, maternal death is when a woman dies from something related to pregnancy, childbirth and 42 days after giving birth (Dina, 2019). And according to the World Health Organization (WHO), maternal death is the death of a woman during pregnancy or within 24 days after the end of pregnancy due to any cause, regardless of the age of pregnancy and the actions taken to terminate the pregnancy. According to WHO, there are several types of causes of maternal death, namely postpartum hemorrhage, high blood pressure, complications in childbirth and unsafe abortion (Dwi, 2019).

Complications in labor that are not handled properly and on time can cause maternal death, around 15% of pregnancies/deliveries experience complications and 85% are normal, one of the complications in labor is placental retention, according to the editorial article of healthy doctors, placental retention is the retention of the placenta in the uterus and does not come out naturally or up to 1 hour after the birth of the baby the placenta has not come out (Endang, 2019).

According to the World Health Organization (WHO) in 2018, it is estimated that every day 830 women die from diseases/complications related to pregnancy and childbirth, this fact is close to one death every minute, among ASEAN countries Indonesia is ranked second in maternal mortality rates, namely 305/100,000 live births. The first position is occupied by Laos 350/100,000 live births, the third position is the Philippines 230/100,000, the fourth position is Myanmar 180/100,000, followed by Cambodia 170/100,000, Vietnam 70/100,000 and finally Malaysia 30/100,000, live births (Endang, 2019).

In Indonesia, maternal mortality is around 305/100,000 live births, according to the 2015 census survey (supas), maternal deaths were caused by 33.07% hypertension, 27.03% obstetric hemorrhage, 15.7% non-obstetric complications, 12.04% other obstetric complications, 6.06% infections during pregnancy, 4.81% other causes (Kirana, 2019).

In Tanjung Balai City, based on the profile of the Tanjung Balai City Health Service in 2017, maternal mortality was 5 per 100/100 live births, 1 person died during pregnancy and 4 people died during childbirth (Tanjung Balai Profile 2017).

Seeing the high maternal mortality rate (MMR) above, the author is interested in studying the problem and presenting it through scientific papers as a form of the author's attention and responsibility to various related parties regarding the problem of placental retention using the approach method "Midwifery Care Management for Mrs; WP: 1 A: 0 with placental retention at the Vivi Rahayu Sitorus Amkeb obstetric clinic in Tanjung Balai City 2020.

The author is interested in taking a case at the Vivi Rahayu Sitorus Amkeb obstetrics clinic because it was recorded that from November 2019 to April 2020, 123 people gave birth, 3 of whom experienced cases of placental retention.

2. RESEARCH METHOD

Midwifery management is a problem-solving process used as a method to organize thoughts and actions based on scientific theories, discoveries, skills in a logical series/stages for making decisions that focus on the client (Walyani, 2017).

Step I: Assessment .

Assessment Is a step to collect all accurate and complete data from all sources related to the client's overall condition. Midwives can conduct assessments effectively, so they must use a standardized assessment format so that the questions asked are more focused and relevant (Walyani, 2017).

a. Subjective Data.

Subjective Data is obtained by conducting anamnesis. Anamnesis is an assessment in order to obtain patient data by asking questions, either directly to the postpartum patient or to the patient's family. An important part of anamnesis is subjective data on postpartum patients which includes:

1) Patient biodata/identity.
2) Main Complaint.
3) Obstetric History.
4) Current Birth History.
5) Medical History.
6) Family Health History.
7) Habits during postpartum period.

b. Objective Data

Objective data can be obtained through physical examination according to needs and examination of vital signs; and supporting examinations. Physical examination is carried out by inspection, palpation, auscultation and percussion.

1) Physical examination includes:
   - General Condition Inspection
   - Patient Awareness
   - Vital signs
   - Head and face (Head, face, nose and ears)

- Teeth and mouth (lips, teeth and gums)
- Neck
- Chest
- Breast
- Abdomen
- Extremities (Upper and Lower Extremities)
- Genitalia (Vagina, Bartholin's glands, vaginal discharge, perineum and anus)

2) Supporting investigation.
Meanwhile, supporting examinations can be obtained through laboratory examinations (Hb levels, hematocrit, leukocytes, blood type), ultrasound, X-rays and so on (Walyani, 2017).

Step 11: Data Interpretation.

a. Data Interpretation.

Basic interpretation is the identification of the diagnosis, problems and needs of postpartum patients. Based on the correct interpretation of the data that has been collected. The diagnosis can be defined, the problem is not:

This step includes:

1) Determining normal conditions
2) Differentiate between discomfort and possible complications.
3) Identify signs and symptoms of possible complications.
    - DO: Delivery on April 28, 2020, at 08.00 WIB
    - *KU: Weak
    - BP: 120/70 mmHg, HR: 92 x/minute, Temp: 36 C, RR: 24 x/minute
    - *Conjunctiva: pale, sclera: not icteric
    - *TFU: 2 fingers below the center
    - *Uterine contractions: Soft

b. Problems.

The problem is formulated when the midwife finds a gap that occurs in the mother's response to the postpartum period. This problem occurs not yet included in the existing diagnosis formulation, but the problem requires midwife handling, then the problem is formulated after the diagnosis. The problem that arises is a statement from the patient, supported by basic data both Subjective and Objective.

Step 111: Diagnose or Potential Problems.

In this step we identify other potential problems or diagnoses based on the series of problems and diagnoses that have been identified. This step requires anticipation, if possible prevention, while observing the client, the midwife is expected to be prepared if the diagnosis or potential problem actually occurs.

Step 1V: Need for Immediate Action.

After formulating the actions that need to be taken to anticipate the diagnosis/potential problems in the previous step, the midwife must also formulate emergency actions that must be formulated to save the mother and baby, independently, collaboratively or by referral based on the client's condition.

Step V: Midwifery Care Plan

In this step, comprehensive care is planned by the previous steps. This step is a continuation of management of the diagnosis or problem that has been identified or anticipated, in this step incomplete basic information/data can be completed. A comprehensive care plan only includes what has been identified from the client's condition or from any related problems but also from the framework of anticipatory guidelines for what is expected to happen next, whether counseling is given and whether to refer the client if there are problems related to economics, culture and psychological problems. Before implementing the care plan, an agreement should be made between the midwife and the patient into informed consent.

1) *Explain to the mother about her general physical condition and provide moral support.
2) Perform uterine massage until strong contractions occur and teach the mother and family how to massage the uterus.
3) Administer oxygen at 2 liters per minute, administer 500cc RL infusion + 20 units of oxytocin 40 drops per minute, inject matergine 0.2 mg IM and amoxicillin IV.
4) Perform external bimanual compression for 3 minutes.
5) Collaboration with dr. SpOG in providing drug therapy.
6) Observe the mother's general condition, vital signs, TFU, vaginal bleeding every 15 minutes in the first hour and 30 minutes in the second hour.

Step V11: Implementation

In this sixth step, the overall care plan as described in step 5 is implemented efficiently and safely. This planning can be done by the midwife or partly by the midwife and partly by the client, or other members of the health team. If the midwife does not do it herself, she still bears the responsibility to direct its implementation. Efficient management will shorten time and costs and improve the quality of client care.

Step V11: Evaluation

In this 7th step, an evaluation of the effectiveness of the care that has been given is carried out, including the fulfillment of the need for assistance, whether it has really been met in accordance with what has been identified in the problem and diagnosis. The plan can be considered effective in its implementation.

3. RESULTS AND DISCUSSIONS

Case Review

1. Data Collection.

A. Identity.

Mother's name	: Mrs. W	Husband's Name: Mr. N	
Age	: 23 years	Age	: 24 years old
Religion	: Islam	Religion	: Islam
Tribes	: Javanese/Indonesian	Tribes	: Javanese/Indonesian
Education	: Senior High School	Education	: Senior High School
Work	: Housewife	Work	: BHL
Home Address	: Sei Dua	Home Address	: Sei Dua

Anamnesis

Date: May 28, 2020 o'clock :03.30 WIB

a. The patient came with complaints of stomach cramps centered on lower back pain and mucus mixed with blood in his underwear at around 02.00 WIB on May 28, 2020.
History of childbirth and pregnancy :
G: 1 P: 0 A:0
1. Types of Childbirth : ☑ Spontaneous / LBK
☐ Artificial
☐ Sect

Indication : Spontaneous labor with retainedplacenta
Date of birth : May 28, 2020 at 15.25 WIB
2. The gender of the child born: man Woman ☑
HPHT : 23-08-2019
TTP : 30-05-2020
Baby born : 05-28-2020 time: 15.25
Gestation period : 41 weeks 5 days ☐
Apgar Score : 9/10
Baby BB : 3300gr

PB : 48cm
Baby Condition : Good

3. Childbirth History.
Types of Persinan : ☑ Spontaneous / LBK
☐ Artificial
☐ Sect.
Amniotomy : ☐ There is ☐ There isn't any
Premature rupture of membranes: ☐ There is ☐ There isn't any
Amniotic Fluid Color : Clear
Smell : Typical
Amount :300cc
Old Time I :1015 minutes
Opening : 10 cm (complete)
Water breaks : ½ hour before delivery.
Old Time II :40minute
Old Time III :50minute
Placenta Birth : ☑ Complete ☐ NoComplete
O'clock : 16.15wib
Number of Telephones :20 pieces
Placenta Weight :500 grams
Umbilical Cord Length :50cm
Tear : ☑ There is ☐ There isn't any
If There Is A Degree Tear: 1 ☐ 2 ☑ 3 ☐ 4 ☐
Old Time IV :2 hours 30 minutes

4. Amount of Bleeding
Time I : ±10 cc
Period II : ±10cc
Period III : ±560cc
Period IV : ±100cc

5. Diseases and Complications
High blood pressure : There isn't any
Seizures : There isn't any
Infection : There isn't any
Etc : There isn't any
If there is, please mention it : There isn't any
Actions during the III period : ☑ there is no there is not
If there is any please explain : ☐ Performing Manual Placenta

6. Post Partum History
a. BAK : elimination pattern :3 x / day
Complaint : ☑ There is ☐ There isn't any
If there is, explain: it feels sore in the perineum area due to stitches.
b. CHAPTER : Frequency :1 x / day
Complaint : ☑ there is ☐ there is not
If there is any please explain: Pain in the rectal area when straining and fear of straining due to fear of the stitches coming open.

7. Rest : Afternoon :2 hours
:O'clock :13.30 to 15.30 WIB
: Complaints: yes or no ☑
: If there is, please explain: there is none ☐

: Evening :8 Hours
: O'clock :21.00 to 5.00 WIB
: Complaint : ☐ there is ☑ no there is not
: If there is, please explain: there is none

8. Eating and Drinking Patterns
   Eat : Rice + vegetables + fruit + side dishes
   Frequency : 3 x a day
   Portion : currently
   Appetite : ☑ Good ☐ not good
   Drink : Water and breast milk for breastfeeding mothers
   The amount :9 glasses / day
9. Mother's acceptance of the baby : ☑ desired ☐ not desired
   Lactation : ☑ givennot given
   Complaints while breastfeeding : ☑ there is no ☐ there is not
   If there is, please mention it : feel pain in the nipple area ☐

B. PHYSICAL EXAMINATION (Objective Data).
1. Emotional status : Good
2. Vital Signs
   2.1. TD : 120/80 mmhg
   Temp : 36.5'c
   BB : 63.5 kg
   HR : 80 x / i
   RR : 20 x / i
3. Special obstetric examination.
   3.1. Breast : ☑ symmetrical ☐ asymmetric
   Nipple : ☐ stand out ☐ not prominent
   Areola Mammary
   Hyperpigmentation : ☑ There is ☐ There isn't any
   Colustorum Expenditure : ☑ There is ☐ There isn't any
   If there is, please mention it : thick yellow color.
   3.2. Abdomen
   Surgery scars : ☑ There is ☑ There isn't any
   3.3. Uterus : ☑ There is ☐ There isn't any
   Consistent : ☐ harden soft
   Uterine Contractions: ☑ There is ☐ There isn't any
   Uterine Position : ☑ anteflexionretroflection
   Frequency : 2 times in 10 minutes
   Duration : 30 x / sec
   3.4. Lochia Discharge : Rubra
   Color : Red
   Smell : typical / fishy
   Contention : Thin
   Volume : ± 80cc
   How many times do you change the doek? :3 x a day
   3.5. Perineum :
   3.5.1. Tear : ☑ There is ☐ There isn't any
   3.5.2. Episiotomy : ☑ There is ☐ There isn't any
   Type : ☐ medialis ☑ mediolateral Lateral
   3.5.3. Cleanliness : ☑ clean is ☐ not clean
   3.6. Hemorrhoids : ☐ There is ☑ There isn't any
   Varicose : ☐ There is ☑ There isn't any

3.7. Bladder : ☑ empty ☐ full
3.8. Extremities
Edema : ☐ There is ☑ There isn't any
Patella reflex :
Left : ☑ There is ☐ There isn't any
Right : ☑ There is ☐ There isn't any
Varicose veins in the legs ☑ There is ☐ There isn't any
Redness on the legs: yes or no
3.9. Supporting investigation :
Blood : O
HB : 10.8 gr %
Leukocytes : There isn't any.

In this discussion, the author will describe the gap between theory and field cases in midwifery care that has been carried out on Mrs. W P: 1 A: 0 Age 23 years with an indication of Placental Retention which was diagnosed with potential midwifery problems, Identification of immediate needs/collaboration, Planning midwifery care, Implementation of midwifery care, and Evaluation of midwifery care. The discussion is as follows: On May 28 - May 31, 2020 in accordance with midwifery care management consisting of 7 systematic steps by Helen Varney, namely data assessment, Identification of midwifery diagnoses/problems, Identification of immediate needs/collaboration, planning midwifery care, Implementation of midwifery care and Evaluation of midwifery care.

After conducting a review of subjective data from Mrs. W, 23 years old, P: 1 A: 0 with placental retention (dr. Taufan Nugroho), the course of the disease/risk factors for placenta previa, history of cesarean section, history of curettage and high birth rate. From these results, there is no gap between the theory and cases obtained from the field.

Nutritional needs during breastfeeding are higher than during pregnancy. The average calorie content of breast milk produced by mothers with good nutrition is 500 calories per day. Eat a balanced diet to get enough protein, minerals and vitamins. Drink at least 3 liters of water every day (Encourage mothers to drink water every time they breastfeed). Iron pills should be taken to increase nutrients for at least 40 days after giving birth. Take Vitamin A (200,000 units) so that you can provide Vitamin A to your baby through your breast milk (Marmi, 2017).

Mothers need additional protein of around 10-15%. Normal needs when breastfeeding such as: Vegetable (Tofu, tempeh, and nuts) Animal (Meat, fish, eggs, shrimp, cheese, milk) From these results there is no gap between theory and cases obtained from the field.

Increased body temperature in the first 24 hours of labor in patients with placental retention is caused by severe bleeding, prolonged pain, fever, and unpleasant odor from the vagina. But in general, after 12 hours, patients with placental retention have normal body temperature if there is no infection and proper treatment. An increase in temperature that reaches (37.5°C-38°C) will indicate signs of infection. From these results, there is no gap between the theory and cases obtained from the field.

In the case of Mrs. W P:1 A:0, an obstetric diagnosis was obtained for the mother giving birth with Placental Retention, the problem was that the mother complained that her stomach still felt painful, the PTT (Umbilical Cord Stretching) did not increase, the umbilical cord was visible in front of the vulva, and the placenta had not been born 30 minutes after the baby was born.

Meanwhile, according to the theory of Placental Retention (Anik Maryunani, 2018), placental retention is when the placenta has not been born after 30 minutes after the baby is born. From these results, there is no gap between the theory and cases obtained from the field.

In the case of Mrs. W P: 1 A: 0 with Placental Retention, the potential diagnosis given to Mrs. W is bleeding, hemorrhagic shock. Meanwhile, according to the theory (dr. Taufan Nugroho, 2016) based on a literature review of emergency obstetric cases of bleeding after childbirth, fever, hemorrhagic shock and can cause death. In accordance with the literature review, Placental Retention

can cause bleeding, death if not handled properly and immediately can cause death. From the results of the study, the potential diagnosis did not occur because it could be handled properly.

In the case of Mrs. W P: I A: 0 with Placental Retention, the immediate action given to the mother is to perform manual placental action. Meanwhile, according to the theory (dr. Taufan Nugroho, 2018), manual placental action is highly recommended in cases of placental retention. From these results, there is no gap between the theory and the cases obtained from the field.

In the case of Mrs. W P: I A: 0 with Placental Retention, inform the mother about her condition, install RL 40 gtt / I infusion, inject oxytocin 20 IU IM, provide oral therapy, immediately perform manual placental action with obstetric techniques.

Meanwhile, according to the theory (Bidan Delima, 2019) The care plan provided is: Patient preparation, installing RL 40 gtt / I infusion, administering oxytocin 20 IU IM injection, administering analgesics and sedatives, performing manual placental action. From these results, there is no gap between theory and cases obtained from the field.

In the case of Mrs. W P: I A:0 with Placental Retention, the steps are to inform the mother about her condition, administer RL 40gtt/I infusion, inject oxytocin 20 IU IM, give oral analgesics, and perform manual placenta removal. Manual placenta action: wash hands in chlorine solution, rinse in DTT solution, dry, bring the mother's emergency equipment close, install a long right hand scoon, vulva hygiene, flush DTT solution on the umbilical cord in front of the vulva, clamp a new clamp on the umbilical cord closest to the vulva (replace clamp C, install clamp B, remove the old clamp), insert the right hand obstetrically, trace the umbilical cord (follow the umbilical cord) until the placenta is found, the left hand is at the fundus of the uterus, find the part that has come loose on the right hand, start incision/scraping on the placenta that has come loose, scrape it with the little finger, remove the placenta, the right hand remains in the uterus to remove the remaining placenta, explore, remove the right hand, massage the fundus of the uterus with the left hand for 15 seconds, check the completeness of the placenta, check for lacerations, dep if there is bleeding. Meanwhile, according to the theory (Bidan Delima, 2019) the care plan provided is: Patient preparation, installing RL 40 gtt / I infusion, administering oxytocin 20 IU IM injection, administering analgesics and sedatives, performing manual placenta. From these results, there is no gap between the theory and cases obtained from the field.

In the case of Mrs. W P:I A:0 with Placental Retention, the mother already knows her condition, the mother has received drug therapy, the mother understands the health education given by the midwife and the mother has carried it out, the mother looks a little calm, the placental removal was successful (the placenta is complete, there is no tear (intact amniotic membrane), the number of complete cotyledons is 20 and the length of the umbilical cord is 50 cm). Monitoring of the fourth period. monitoring of the fourth period is carried out for 2 hours, the first hour every 15 minutes and the second hour every 30 minutes, the purpose of monitoring the fourth period is to determine bleeding, uterine contractions and vital signs. Monitoring of vaginal bleeding: vaginal bleeding in the fourth period is still considered normal, amounting to 80 cc in monitoring for 2 hours, likewise in the postpartum period, vaginal bleeding is still considered normal and reasonable, amounting to 100cc/day. Monitoring uterine contractions: uterine contractions are good and strong, as evidenced by the movement of the mother's uterine involution which from day to day is like a mother giving birth normally in general, assessment of uterine contractions begins from the fourth stage of labor until 3 days of the mother's postpartum period, uterine contractions are classified as good and there are no problems to be afraid of. Meanwhile, according to the theory (Anggraini, 2016), this step is the last step to find out what the midwife has done. Evaluate the effectiveness of the care provided, repeat the management process correctly for each aspect of care that has been implemented if it is not yet effective or re-plan what has not been implemented. From these results, there is no gap between theory and cases obtained from the field.

4. CONCLUSION

The conclusion of this scientific paper (KTI) is as follows. Conducting a midwifery care assessment on Mrs. W, a mother giving birth with placental retention through anamnesis, physical examination, then

the data obtained is analyzed into subjective and objective data. Identifying the diagnosis/obstetric problem on Mrs. W, a mother giving birth with placental retention is placental retention/unborn placenta. Identifying the diagnosis/potential obstetric problem on Mrs. W, a mother giving birth with placental retention and the diagnosis/potential problem is Hemorrhagic Shock. From the diagnosis/problem on Mrs. W, a mother giving birth with placental retention, immediate action, collaboration and consultation with other health workers are needed. Planning midwifery care actions on Mrs. W, a mother giving birth with placental retention and the potential for postpartum bleeding, infection, fever and hemorrhagic shock. Implementing midwifery care on Mrs. W, a mother giving birth with placental retention from the first, second, and third days of the postpartum period. Evaluating the results of midwifery care for Mrs. W, a mother who gave birth with retained placenta, that the problem could be resolved as a whole.

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