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Midwifery Care for Pregnant Women Mrs. R with Preeclampsia at Veronica Clinic, Stabat Lama Village, 2019

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ABSTRACT

The results of the 2012 Indonesian Demographic and Health Survey (IDHS) stated that the MMR in Indonesia was 359 per 100,000 KH. According to the Indonesian Health Profile, the highest causes of maternal mortality in 2013 were bleeding, Hypertension in Pregnancy (HDK), infection, prolonged/obstructed labor and abortion. Mothers who experience hypertension due to pregnancy range from 10%, 3.4% of them have pre-eclampsia, 5% have hypertension and 1-2% have chronic hypertension. Type of case study report with descriptive method, location at BPS Deniawati Kwala Bingai Stabat. 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 mild pre-eclampsia using Varney's 7-step midwifery approach. Results For midwifery care for pregnant women at BPS Rusnah after carrying out midwifery care for 3 weeks the results were: Blood pressure 150/90 mmHg, to 120/80 mmHg, Urine protein from (+1) to (-). Although in this case there is a gap between theory and practice, the midwife can provide care to the patient so that a potential diagnosis in the form of severe pre-eclampsia does not occur. The results of midwifery care carried out for 3 weeks were the mother did not feel dizzy anymore, blood pressure became 120/80 mmHg, urine protein (-) and there was no edema in the left and right legs (pregnant women did not experience pre-eclampsia anymore).

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1. Introduction

Maternal mortality can be an indicator of health status. Maternal Mortality Rate (MMR) in the world reaches 289,000 people which is divided into several countries, including the United States reaching 9300 people, North Africa 179,000 people and Southeast Asia 16,000 people. Maternal mortality rate (MMR) in Southeast Asian countries such as Malaysia (39/100,000 live births), Thailand (44/100,000 live births), the Philippines (170/100000 live births), Brunei Darussalam (60/100,000 live births), Vietnam (160/100,000 live births), and Singapore (3/100,000 live births). The number of MMR in Indonesia is still relatively high when compared to other Southeast Asian countries(Anjani, nd).

The Maternal Mortality Rate (MMR) in Indonesia in 2014 reached 214 per 100 thousand live births, a decrease compared to the 2012 MMR which was 359 per 100 thousand live births (DepKes RI, 2015). According to the International Federation of Obstetrics and Gynecology (FOGI) pregnancy is the fertilization or union of spermatozoa and ovum followed by nidation or implantation. If calculated from fertilization to the birth of the baby, a normal pregnancy will take place in 40 weeks or 10 months or 9 months according to the international calendar. Pregnancy is divided into 3 trimesters, where the first trimester lasts for 12 weeks, the second trimester is 15 weeks (weeks 13 to 27), and the third trimester is 13 weeks (weeks 28 to 40 weeks).(Putri & Respitowati, 2018).

According to the Indonesian Health Profile, the highest causes of maternal mortality in 2013 were bleeding, Hypertension in Pregnancy (HDK), infection, prolonged/obstructed labor and abortion. Maternal mortality in Indonesia is dominated by three main causes, namely bleeding, hypertension in pregnancy (preeclampsia) and infection. The proportion of the three causes of maternal death has changed, where bleeding and infection tend to decrease, while the proportion of preeclampsia is increasing. More than 30% of maternal deaths in Indonesia in 2010 were caused by hypertension in pregnancy.(Sabgustina & Anjani, 2018).

One of the causes of death for pregnant and maternity women is preeclampsia and eclampsia. Therefore, it is necessary to treat preeclampsia and eclampsia to reduce maternal mortality and infant mortality. Maternal mortality is caused by lack of knowledge about the signs of pregnancy, gestational age that is too young or too old, low education, low family income as well as medical aspects and one of them is Preeclampsia which is very influential in increasing maternal mortality.(Roeshadi, 2007).

Preeclampsia is a syndrome characterized by increased blood pressure and proteinuria that appears in the second trimester of pregnancy and resolves after delivery. Preeclampsia can occur in the antenatal, intranatal and postnatal period. Mothers who have hypertension due to pregnancy range from 10%, 3.4% of them have pre-eclampsia, 5% have hypertension and 1-2% have chronic hypertension.(Sutrimah et al., 2015).

Reduction in morbidity and mortality due to pre-eclampsia can be achieved if preventive measures and disease diagnosis are carried out early and treatment as soon as possible. Early prevention efforts can be carried out if the main causative factors and risk factors for pre-eclampsia can be identified(Sinabariba, 2018).

Preeclampsia is influenced by several factors, namely primigravida or >10 years since the last birth, previous history of preeclampsia, family history of preeclampsia, multiple pregnancies, certain medical conditions. Pre-eclampsia and eclampsia are ongoing complications of pregnancy with the same cause. Therefore, prevention or early diagnosis can reduce the incidence and reduce morbidity and mortality. In order to be able to establish an early diagnosis, regular monitoring of pregnancy is required by paying attention to weight gain, increased blood pressure, and urine examination to determine proteinuria(Astuti, 2015).

2. Method

2.1 Case Study Type

This report is a type of case study that uses a descriptive method with the main objective of making an objective description or description of a situation (Notoatmodjo, 2010)..

2.2 Case Study Locations

Is the place or location used to take case reports. This case report was carried out at the Veronica Clinic in Stabat Lama Village. Case study time is the period of time needed by the author to obtain data for the research carried out. This case study was conducted on 26 May, 3 June and 10 June 2019.

2.3 Data Collection Techniques

Primary data is data collected by themselves when performing midwifery care for pregnant women with mild preeclampsia (Notoatmodjo, 2010). And secondary data is data collected by people conducting research from existing sources. Obtained from the library or from previous research (Notoatmodjo, 2010).

Documentation Data are all forms of information sources related to documentation. In this case, the documentation was done by collecting data taken from the patient's medical records at the Veronica Clinic, Stabat Lama Village. Literature Studies are library materials that support the theoretical background in a study (Notoatmodjo, 2010). In this case, literature studies by collecting library books published in 2010-2015.

3. Results and Discussion

3.1 Identity

Name	Mrs. R	Name	Mr. R
age	24 years old	Age	29 years

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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	Old Stabat		Home address	Old Stabat	

3.2 History (Subjective Data)

At the date of :26 - 05 – 2019 O'clock : 14.00 WIB

a. Reason for Visit : £firstRegular £ Irregular
b. Complaint : Headache, head feels dizzy, looksedema of the legs
c. Menstrual History :
   First Menstruation : Age 15 years
   Regular £ Irregular
   Cycle : 28 day Duration: 7 days
   Amount : 3 x change dock
   Blood Nature :Dilute £ Thick
   Dysmenorrhea :£ Yes None
d. Past Pregnancy, Childbirth and Postpartum 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 i	stat e	Lac-tasia
1	H	a	m	i	l		I	n			

e. History of this pregnancy
   HPHT : 23 – 10 - 2018
   TTP : 30 – 07 - 2019
   Complaints in the first trimester : Nausea and Vomiting
   2nd trimester : There isn't any
   Third Trimester : Head hurts and feels dizzy
   First Fetal Movement : 16 weeks
   If movement is felt, the child's movements in the last 24 hours:
   £ < 10 x 10x – 20x £ > 20x
   If more than 20 times in 24 hours, with frequency:
   £ < 15 minutes > 15 minutes
f. 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 is
   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 isn't any
   Reddish pain, tension in the legs : There isn't any
   Edema : There is
   Dietary habit : Before Pregnancy : After Pregnancy:
   Frequency : 3 x 1 - Frequency : 3x1
   Portion : Rice + vegetables + side dishes
g. Changes in eating experienced include cravings, appetite and others.
   Before pregnancy : There isn't any
   After pregnancy : There is
   Elimination pattern :
   • CHAPTER • BAK

Before pregnancy : 2 x a day Before pregnancy : 3 times a day
After pregnancy : 1 x a day After pregnancy : 5 times a day

h. Daily activities
Rest and Sleep Pattern :
Evening : 22.00 wib to 06.00 wib
Complaint : £ There None
Afternoon : 13.00 wib to 14.00 wib
Complaint : £ There None
Work : IRT activity
Sexuality : According to the needs
Frequency : According to the needs
Complaint : There isn't any
TT1 Immunization : 20 –01- 2019 TT2 immunization : 20– 02– 2019
Contraceptives ever used: None

i. History of systemic disease that has been suffered
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

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

k. Social History
Marriage
Marry I : 2018
duration : - year someone's child
Married II :
Pregnancy : Planned £None
Planned :Received £None

i. Feelings about this pregnancy : anxious because the head often feels
j. dizzy, afraid that something unexpected will happen to her pregnancy

3.3 Physical Examination (Objective Data)

a. Emotional status: Stable
Vital sign
Blood pressure : 150/90 mmHg BB beforepregnant : 51 kg
Pulse : 82 x/i BB now : 68 kg
Body temperature : 37o C TB :156 cm
RR : 24 x/i LILA :30 cm

b. Head
Hair : £ There None

c. Face
Chloasmagravidarum : £ Ada None
Edema : £ There None
Eye
Conjunctiva : £ Pale No
Sclera : £ Jaundice No
Nose : No enlargement of polyps
Mouth : No stomatitis, no caries
Ear : No pathological cerumen

d. Neck :
Enlarged lymph nodes £ Yes None
Complaint : There isn't any

e. Axial

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Enlarged lymph nodes £ Yes None
Enlargement of the thyroid gland £ Yes None

f. Chest : Symmetrical
Mammae
Enlargement : Symmetrical
Bump : £ There None
striae : There isn't any
Areola : Hyperpigmentation
Nipples : stand out
Expenditure : there is

g. Abdomen
Enlargement : In accordanceGestational Age
striae : There is
Be for : Symmetrical
Linea : There is
Surgical scars : £ There None

h. Palpation
TFU : 29 cm
Back : Right
Percentage : Head
Decrease : Not yet in PAP

i. Auscultation
DJJ :136 x/i
Frequency :Regular £ Yes
Punctum : Center right lower quadrant
Bladder : empty

j. Pelvic
Spinarum dystonia : 27 cm
Cristarum dystonia : 32 cm
External distance : 18 cm
Hip Circumference : 100 cm
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

k. Upper and lower extremities
Edema : There is
Varices : There isn't any
Reflex :Yes £ None.

3.4 Diagnostic Test

Hb :12 gr%
Urine Protein : (+1)
Urine Glucose :

3.2 Discussion

In this discussion the author will explain about the gaps that occur between the practice carried out in the field with the existing theory. This discussion is intended to draw conclusions and solve problems from the gaps that occur so that they can be used as a follow-up in the implementation of effective and efficient midwifery care, especially for pregnant women with mild pre-eclampsia.

In this discussion the authors will discuss based on the midwifery care management approach with seven steps, namely identification of basic data, identification of actual diagnoses/problems, identification of potential diagnoses/problems, implementing immediate action/collaboration, planning midwifery care actions, implementing midwifery care and evaluating midwifery care. In the application of the midwifery care management process to Mrs "R" with mild preeclampsia cases,

it is carried out through the following stages:.

a. Step I: Identification of Base Data

Identification of basic data is a midwifery care management process aimed at collecting information both physical, psychosocial and spiritual (Nurhayati et al, 2013). The information obtained regarding these data was obtained by conducting direct interviews with clients and their families and partly from physical examinations, and supporting/laboratory examinations.

According to Wiknjosastro (2010), pregnant women with mild preeclampsia are pregnant women who complain of dizziness and swollen feet, pregnant women with a gestational age of more than 20 weeks accompanied by blood pressure of 140/90 mmHg or general edema of the fingers or toes and face or an increase in blood pressure. weight 1 kg or more per week and urine protein (+). In the case of Mrs. R G1P0A0 pregnant 30 weeks 3 days accompanied by complaints of dizziness and swollen legs, blood pressure 150/100 mmHg, leg edema, urine protein (+). a lot of weight gain. So in the study there is no gap between theory and practice in the field.

b. Step II: Identify the Diagnosis/Actual Problem

The second step is to identify the diagnosis or problem based on the correct interpretation of the data that has been collected. The data is then interpreted so that specific diagnoses and problems can be formulated (Nurhayati, Aprina. 2013).

According to Manuaba in 2010 the problem in pregnant women with mild pre-eclampsia is feeling anxious about their pregnancy and their fetus. While the needs of pregnant women with mild pre-eclampsia are to provide mental support to the mother and explain the state of her pregnancy, provide counseling/information about mild pre-eclampsia and its effect on pregnancy. In this case, the author obtained a midwifery diagnosis of a pregnant woman Mrs. R, GI, P0, A0, 30 weeks 3 days of gestation, right back, head percentage, not yet admitted to PAP, live and single fetus with mild preeclampsia. Problems found in pregnant women Mrs. R is the mother feels anxious about the state of her pregnancy and the fetus. In this step the writer finds no gap between theory and practice.

c. Step III: Identify the Diagnosis/Potential Problem

In this step, we identify problems or other potential diagnoses based on the set of diagnoses and problems that have been identified. Identifying potential diagnoses is anticipating everything that might happen (Mangkuji Betty, 2013). .

According to Manuaba (2010), in mild preeclampsia a potential diagnosis can occur severe preeclampsia which is characterized by blood pressure of 160/110 mmHg, urine protein more than 3 grams/liter and the presence of pulmonary oedema. While in the case of Mrs. There were no signs suggesting severe pre-eclampsia, meaning that a potential diagnosis of severe pre-eclampsia did not occur. Therefore, in this step the author did not find any potential diagnoses because Mrs. R has received proper midwifery care and good cooperation between patients, midwives, ob-gyn doctors and families.

d. Step IV: Immediate Action/Collaboration

Immediate action and collaboration are carried out based on indications that require fast and appropriate treatment so that collaboration with health professionals who are experts in their fields is required. In this case, there is no indication that requires the mother to be given immediate action, except when the mother comes in a state of shock, unconscious or fainting, immediate action can be taken to install oxygen. The only anticipation that must be done for pregnant women with mild preeclampsia is to collaborate with obstetricians to prevent severe preeclampsia, as well as collaboration with laboratories to detect the development of mild preeclampsia into severe preeclampsia by checking the presence of urine protein.

In the case of Mrs. The anticipatory steps carried out by the midwife are monitoring blood pressure, FHR, Urine Protein, Oedema and collaborating with Obgyn doctors. So in this step there is no gap between theory and practice in the field.

e. Step V: Parenting Plan

This step is a continuation of obstetric management of the diagnosis or problem that has been identified or anticipated. A plan of action must be agreed upon by the patient and the midwife to be effective. All decisions made in planning a comprehensive care must reflect sound rationale based on current and relevant knowledge, theory, and have been validated against the wishes or needs of the patient.

Making an action plan for midwifery care should determine the purpose of the action to be taken which contains the goals/targets and the results to be achieved in the application of

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midwifery care to Mrs "R" with mild preeclampsia during pregnancy.

According to Wiknjosastro (2010), the management of mild pre-eclampsia is divided into, in general, including monitoring blood pressure, urine protein and fetal condition, getting enough rest, namely during the day ± 2 hours and night ± 8 hours, regular diet high protein foods, high carbohydrates, enough vitamins and low in fat, the provision of supporting drugs namely Vitamin B complex (dizziness, nausea, vomiting, headache), Vitamin C (immune system in pregnancy), Fe/iron tablets (blood booster) and Advice More rest, come immediately for a checkup If you have headaches, blurred vision, anasarca (whole body) edema, weight gain, shortness of breath, epigastric pain, decreased consciousness, weakened fetal movements, and little urine output.

In the case of Mrs. The plan given is almost in accordance with the opinion of Wiknjosastro (2010), only administering oral drug therapy in collaboration with ob-gyn doctors Nifedipine 10 mg. blood pressure. So there is a gap between theory and practice in the field, namely blood pressure monitoring is only carried out during checkups because the mother is not treated at the Veronica Clinic in Stabat Lama Village and urine protein is carried out 3 times for 3 checks because the urine protein test results are negative.

f. Step VI: Implementation

Based on the midwifery care management review that implementing the action plan must be efficient and ensure a sense of security for the client. Implementation can be carried out entirely by midwives or partially carried out by patients and in collaboration with other health teams in accordance with planned actions (Mangkuji et al, 2013)

In this case, Mrs "R", with a diagnosis of mild preeclampsia during pregnancy. In this case, the diagnosis was made based on history, physical examination and supporting examinations. The management of care in the case study of Mrs "R" with mild preeclampsia, all planned actions can be carried out completely well and do not find serious obstacles because of cooperation and good acceptance from cooperative clients and families as well as supporting facilities and facilities in implementation of the action at the Veronica Clinic in Stabat Lama Village. In the implementation of midwifery care, the author did not find significant obstacles because all the actions taken were oriented to the client's needs.

g. Step VII: Evaluation of Midwifery Care

Evaluation is the final step of the midwifery management process where at this stage progress or success is found in overcoming the problems faced by clients. The evaluation process is a step of the midwifery care management process at this stage the authors did not get any problems or gaps in the evaluation indicating the problem was resolved without any complications (Mangkuji, 2013).

In this seventh step, the comprehensive care plan as described in the sixth step is carried out efficiently and safely. It is carried out by the midwife or in part by the client or other members of the health team (Varney, 2010). In the case of pregnant women with mild pre-eclampsia, they have received treatment according to the plan that has been made and implemented by ob-gyn doctors, midwives and clients.

In the case of Mrs. R after monitoring for 3 weeks, at 30 weeks of gestation, the results showed that blood pressure had dropped to 120/80 mmHg and there was no edema within 2 weeks and urine protein within 3 weeks but even so, monitoring still needs to be done with the recommendation of more control often so that when something unexpected happens it will be quickly resolved. So in handling the case of Mrs. R was as expected, although there was a slight gap between theory and practice in the field, namely a low-salt diet guide, the frequency of urine protein examination was only carried out 3 times, blood pressure was only carried out during check-ups because the mother was not treated at the Veronica Clinic in Stabat Lama Village. .

4. Conclusion

In the last chapter of the preparation of Scientific Papers with Case Studies, entitled “Midwifery Care for Pregnant Women, Ny. R with Pre-eclampsia at the Veronica Clinic, Stabat Lama Village in 2019”, the author can make the following conclusions: After midwifery care was carried out on Ny. R GI P0 A0 with moderate pre-eclampsia at the Veronica Clinic, Stabat Lama Village using 7 steps of Varney, it can be concluded, as follows. Ny. R GI P0 A0 with mild preeclampsia but if not treated, a potential diagnosis is found, namely severe preeclampsia. With comprehensive obstetric care, no potential diagnoses were found in this case. The results of midwifery care carried out for 3

weeks were the mother did not feel dizzy anymore, blood pressure became 120/80 mmHg,

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