MIDWIFE CARE IN NY. W 29 YEARS OLD WITH RETENTION OF PLACENTA IN THE MIDWIFE CLINIC L. PANGARIBUAN VILLAGE SIMANTIN PANE DAME OF THE YEAR 2020

Chintani Sihombingr[1], Zhenyu Cui[2], Ficha Aulia Nanda[3], Herna Jusnita Samosir[4], Nur Mazdalifah[5].
Program Studi Kebidanan, Universitas Efarina[1],[3],[4],[5].
Stevens Institute of Technology, New Jersey USA[2].

*Correspondence: cintani03@gmail.com

Abstract

This study aims to determine the midwifery care in NY. W 29 years old with retained placenta at the L.pangaribuan midwife clinic in Simantin Pane Dame village in 2020. The results of the study show thatIn the study of the case of the mother in the third stage of labor in Mrs. W aged 29 years with retained placenta, subjective data was obtained with the main complaint, namely the mother felt worried because the placenta had not yet been born, the mother felt tired and weak and the mother said that in the first delivery she had done manual placenta. While objective data obtained general state data is weak,composmental Consciousness, TTV : BP : 110/70 mmHg,Q:78x/i, T : 36 0C,RR : 24x/i,umbilical cord does not extend at the vulva,bleeding ± 150 cc,placenta not delivered after 30 min, weak contractions,TFU : as high as the center. Based on this, there is no gap between theory and practice.Anticipating potential problems made to Mrs. W 29 years old with retained placenta is to put infusion + oxytocin 20 units in 500 cc RL, give metergin 10 units/IM and antibioticsCeftriaxone 3cc and the placenta was done manually, but in anticipating the problem of infection was still high because long gloves were not provided in the manual procedure of the placenta. Based on this found a gap between theory and practice.

Keywords: Midwifery Care, Placenta Retention

INTRODUCTION

A country's health indicator is determined by a comparison of the high and low maternal mortality rates (MMR) and infant mortality rates (IMR). Indonesia within the ASEAN environment is a country with the highest maternal mortality rate, which means that the country's ability to provide health services still requires comprehensive and higher quality improvements. (Manuaba, 2012)

The goal of development in the health sector towards a healthy Indonesia 2015 is to increase awareness, willingness and ability to live a healthy life for everyone so that the highest possible increase in public health status can be realized, so that it is an investment in improving the quality of human resources. Health development that has been carried out continuously in the last three decades has succeeded in significantly improving the health status of the community. (RPJPK, 2009)

WHO estimates worldwide every year more than 585,000 people per year die during pregnancy or childbirth. According to WHO data, as many as 99% of maternal deaths due to labor or birth problems occur in developing countries. MMR in developing countries is the highest with 516 maternal deaths per 100 thousand KH, while IMR in 2011 was 42 per

1,000 KH. When compared with the ratio of maternal mortality in nine developed countries and 51 commonwealth countries (Mudanija, 2011).

Based on WHO research in Indonesia, the maternal mortality rate is 330/100,000 live births. This shows that the ability of obstetric services has not touched the community. Maternal mortality is estimated at around 16,500-17,500 per year (Manuaba, 2008)

MMR in Southeast Asia in 2012, namely Singapore was only 6/100,000 KH, Malaysia was recorded at 41/100,000 KH, Thailand was 44/100,000 KH and the Philippines was 170/100,000 KH. While Indonesia is classified as the highest with an average rate of 228/100,000 KH. Based on the 2012 human development report, IMR reached 31/1,000, which is 5.2 times higher than Malaysia, 1.2 times higher than the Philippines and 2.4 times higher than Thailand. The high MMR and IMR put Indonesia at the top of the Association of South East Asian Nations (ASEAN) (Puspita, 2012).

Based on the 2011 Indonesian Demographic and Health Survey (IDHS), the Maternal Mortality Rate (MMR) in Indonesia is still at 102 per 100,000 live births. Based on surveys, the most maternal deaths occur during childbirth, therefore deliveries require close monitoring so as to prevent some of these deaths (Ministry of Health, 2012)

The causes of maternal death during childbirth are 28% bleeding, 24% eclampsia, and 11% infection, while indirect causes include chronic energy deficiency (KEK) of 37% and anemia of 40% in pregnant women (Kumalasari et al, 2012)

The maternal MMR reported in North Sumatra in 2012 was only 106/100,000 live births, but this cannot yet describe the actual MMR in the population. Based on the results of the 2010 Population Census, MMR in North Sumatra was 328/100,000 KH, this figure is still quite high when compared to the 2010 SP results national figure of 259/100,000 KH. (Ministry of Health, 2012)

Stage III labor begins after the birth of the baby and ends with the birth of the placenta and amniotic membranes. The aim of active management of the third stage is to produce effective uterine contractions so as to shorten the time of the third stage, prevent bleeding and reduce blood loss in the third stage of labour. (Rohani et al, 2011)

Most cases of maternal morbidity and mortality in Indonesia are caused by postpartum haemorrhage which is mostly caused by uterine atony or retained placenta which can actually be prevented by active management of the third stage (Ministry of Health RI, 2009)

The maternal mortality rate in Indonesia due to bleeding is still quite high, one of which is retained placenta, namely the placenta has not been born after half an hour after the baby is born, so it requires intensive monitoring and appropriate treatment to reduce bleeding, especially due to retained placenta.

LITERATURE REVIEWS

Labor

Childbirth is a process of expelling the products of conception (fetus, amniotic fluid, placenta and amniotic membranes) from the mother's uterus through the birth canal or by other means, which then the fetus can live in the outside world (Rohani, et al., 2011)

Childbirth is a series of events that end with the expulsion of a full-term or nearly full-term baby followed by the expulsion of the placenta and fetal membranes from the mother's body (Ambar, 2011)

Postpartum Hemorrhage

Bleeding is the event of large amounts of blood coming out of the vagina or bleeding as a result of rupture of the vessels. Postpartum hemorrhage is all bleeding that occurs after the birth of the baby, namely before, during and after the release of the placenta with blood loss > 500 ml. (Oxorn and Forte, 2010)

Placental Retention

Retention of the placenta is the delay in delivery of the placenta for half an hour after delivery of the baby. (Manuaba, 2012)

Retention of the placenta is when the placenta remains in the uterus half an hour after the child is born due to strong adhesion between the placenta and the uterus. (Sarwono, 2012)

METHODS

Step I (first): Collection of Basic Data

In this first step, an assessment is carried out by collecting all the data needed to evaluate the client's condition in full, namely:

1. Medical history
2. Physical examination as needed
3. Review recent notes or previous notes,
4. Review laboratory data and compare with study results

In this first step, all accurate information is collected from all sources relating to the client's condition. The midwife collects complete initial basic data. If the client has complications that need to be consulted with the doctor in collaboration management the midwife will carry out the consultation. In certain circumstances it may happen that the first step will overlap with 5 and 6 (being part of these steps) because the data needed is taken from the results of laboratory tests or other diagnostic tests. Sometimes midwives need to start management from step 4 to get initial baseline data that needs to be conveyed to the doctor.

Step II (second): Basic Data Interpretation

In this step, the correct identification of the diagnosis or problem and the client's needs is carried out based on the correct interpretation of the data that has been collected. The basic data that has been collected is interpreted so that a specific problem or diagnosis is found. The words problem and diagnosis are both used because some problems cannot be solved like a diagnosis but really require handling which is poured into a plan of care for the client. Problems often relate to women's experiences as identified by midwives. This problem often accompanies the diagnosis. For example, the diagnosis is “probable pregnant woman”, and the problem associated with this diagnosis is that the woman may

not want to have a pregnancy. Another example is that women in the third trimester feel afraid of the process of labor and delivery which can no longer be postponed. Feelings of fear are not included in the "Nomenclature Standard Diagnostics" category but will certainly create a problem that requires further study and requires a plan to reduce fear.

Step III (third): Identify Diagnostics or Potential Problems

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

At this stage it is very important to carry out safe care. Example of a woman with excessive expansion of the uterus. The midwife must consider possible causes of the excessive dilation of the uterus (eg polyhydramnios, size for gestational age, mother with gestational diabetes, or multiple pregnancies). Then she must anticipate, make plans to deal with it and be prepared for the possibility of sudden postpartum hemorrhage caused by uterine atony due to excessive expansion of the uterus. In deliveries with large babies, midwives should also anticipate and be prepared for the possibility of shoulder dystocia and also the need for resuscitation. Midwives should also be aware of the possibility of a woman suffering from urinary tract infections which causes a high increase in the possibility of preterm labor or small babies. A simple preparation is to ask and review the history of pregnancy at each return visit, laboratory tests for symptomatic bacteria and immediately provide treatment if a urinary tract infection occurs.

Step IV (fourth): Identify and Determine Needs Requiring Immediate Handling

Identify the need for immediate action by a midwife or doctor to be consulted or handled together with other members of the health team according to the client's condition.

The fourth step reflects the continuity of the midwifery management process. So management is not only during periodic primary care or prenatal visits, but also as long as the woman is with the midwife continuously, for example when the woman is in labour. New data may need to be collected and evaluated. Some data may indicate a dire situation in which the midwife must act immediately in the interests of the life of the mother or child (eg, haemorrhage in stage III or immediately after birth, shoulder dystocia, or low APGAR scores). From the data collected, it can indicate a situation that requires immediate action while others must wait for intervention from a doctor, for example, prolapse of the umbilical cord.

Likewise, if there are early signs of pre-eclampsia, pelvic abnormalities, heart disease, diabetes or serious medical problems, midwives need to consult or collaborate with doctors. Under certain conditions a woman may also need consultation or collaboration with a doctor or other health team such as a social worker, nutritionist or a newborn clinical nurse expert. In this case the midwife must be able to evaluate the condition of each client to determine who is the most appropriate consultation and collaboration in client care management.

Step V (fifth): Planning Comprehensive Care

In this step, comprehensive care is planned, determined by the previous steps. This step is a continuation of the management of the diagnoses or problems that have been identified or anticipated, in this step incomplete reform / basic data can be completed. The comprehensive plan of care includes not only what has been identified from the client's condition or from any related problems but also from the anticipatory framework for the woman, such as what is expected to happen next, whether counseling, counseling is needed, and whether it is necessary to refer the client if there is a problem. -problems related to socio-economic, cultural or psychological problems. In other words, his care for this woman already includes everything related to all aspects of upbringing. Each care plan must be approved by both parties, namely by the midwife and the client, so that it can be implemented effectively because the client is part of the implementation of the plan. Therefore, in this step the midwife's task is to formulate a plan of care in accordance with the results of discussing the plan with the client, making a mutual agreement before carrying it out. All decisions developed in this comprehensive care must be rational and truly valid based on up to date knowledge and theory and in accordance with assumptions about what the client will or will not do. Rational means not based on assumptions, but according to the client's condition and correct and adequate theoretical knowledge or based on a complete basic data,

Step VI (sixth): Implement planning

At this step the overall care plan as described in step five is carried out efficiently and safely. This planning can be done by the midwife or partly done 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 for directing its implementation (eg ensuring that the steps are actually implemented). In situations where the midwife in the management of care for the client is responsible for implementing the overall plan of care together.

Step VII (seventh): Evaluation

In this VII step, an evaluation of the effectiveness of the care that has been given includes meeting the need for assistance, whether it has really been fulfilled according to what has been identified in the diagnostic problem.

RESULTS AND DISCUSSION

Results

VISIT 1

subjective :

- Mother said she gave birth to a baby boy last night at 17.00
- Mother is happy for the birth of her baby
- The mother said that the milk had come out a little but still felt pain in the stomach and stitches
- Mother said she was moving in bed but had not started walking

Objective :

- circumstances :Good
- awareness : composmentis

- TTV :- TD : 110/70mmHg
  - RR : 20 times/minute
  -HR : 80 times/minute
  - T : 36^{o}C
- Fundal height: 2 fingers below the center.
- The milk is out
- Good contractions
- Lochia : rubra (fresh red)

Assessment

Diagnosis: Mother PII Ao Post Partum 1 day with a history of retained placenta, the condition of the mother is good.

Problem : 1 day postpartum mothers with retention

Need : - health education about breastfeeding in infants
- education about mobilization
- health education about personal hygiene
- health education about danger signs of puerperium
- monitor bleeding

Planning

1. Inform the mother and family of the results of the mother's examination under normal circumstances

   general state : Good

   TTV : - TD : 110/70mmHg
   - RR : 20 times/minute
   -HR : 80 times/minute
   - T : 36^{o}C

   Fundal height : 2 fingers below center .

   - The milk is out
   - Contraction : Good

   Lochia : rubra (fresh red

   bleeding ± 30cc and has started to decrease

   Ev: You already know the results of the examination
2. Detect postpartum complications, such as postpartum bleeding due to uterine atony or if the mother's lochia is found to smell and the uterus does not involute properly.

   Ev: Mother has been examined for signs of complications that may be experienced and found no signs of complications.
3. Advise the mother to always give the baby breast milk without being scheduled when the baby wants to suckle. If the mother feels pain and tenderness in the breast, do breast care.

   Ev: mother promised to always give her baby breast milk
4. Advise mom to start walking around the room

   Ev: You will do it accompanied by your husband
5. Encourage mothers to consume lots of vegetables, fish and fruit

Ev: You already understand

6. Advise the mother to take a bath and clean the genital area, especially the stitched area. Start cleaning from the front area to the back.
   Ev: mother understands and will take a bath
7. Encourage mothers to maintain personal hygiene, especially the genital area / perineum. If it is damp or wet, advise the mother to immediately change clothes/underwear.
   Ev: You already understand

VISIT II

Assessment date: 25 – 06 - 2020
Time: 09.05 WIB
Place: Mrs. W

subjective

1. Mother says things are good
2. Mother admits that there are no problems in defecating and urinating
3. Mother says she doesn't feel heartburn anymore
4. Milk comes out a lot in the left and right breasts
5. Mother said there was still brownish blood coming out of her vagina

O (Objective)

1. General condition : Good
   Awareness : compromise
2. Vital signs

TD :110/70 mm Hg
\r : 20 times/minute
P : 82 times/minute
temp : 36.5 0 C

3. Physical examination

a. Advance :No edema and no pale b. Eye : Pink conjunctiva, white sclera
c. Breast : Nipples protrude and clean, colostrum comes out, no masses and breasts are not felt hard, milk comes out smoothly from the right and left breasts
d. Abdomen : symmetrical, mid-central TFU, and bladder empty bladder e. Genetalia : Vulva vagina clean and no abnormalities, there is lokea sanguilenta, and the consistency is watery f. Extremity : no edema, no varicose veins, patellar reflex positive

Assasment

Diagnosis : Mrs. W is 29 years old$_2$A0 postpartum 6 days
Problem : There isn't any

Need : Postpartum care at visit II

Planning

date : 25-04-2020 O'clock :09.20 By : Diccey

1. Notify the results of the examination to the mother and family that the condition of the mother at this time is good and normal.

   Evaluation: Mother and family understand the results of the examination and are happy to hear them.
2. Ensure uterine involution is proceeding normally and detect abnormal bleeding by feeling the mother's abdomen with both hands and looking at the mother's lochia and the amount of blood coming out of the mother's genitals.

   Evaluation: TFU is not palpable, there is no abnormal bleeding and odor and the mother already knows it.
3. Review the mother about the danger signs during the puerperium, namely:
   a. The uterus feels soft / does not contract
   b. Vaginal bleeding > 500 cc
   c. Severe headache
   d. Pain / heat when urinating
   e. Blurred vision
   f. Foul-smelling vaginal discharge
   g. High fever where the mother's body temperature is> 380C

   Evaluation: You understand and if there are any of these danger signs, you will immediately come to the nearest health service.
4. Providing health education about how to breastfeed properly and correctly, namely by:
   a. Advise the mother to breastfeed the baby as often as possible, do not schedule the baby's feedings so that milk continues to be produced with the baby's suction.
   b. Advise mothers to try several breastfeeding positions until they find the most appropriate position for the baby to suck milk optimally.
   c. Advise the mother to give breast milk when the baby is not sleepy, so the baby can suckle firmly.

   Evaluation: Mother understands and says she will carry out the midwife's advice.
5. Providing health education about nutrition and fluids, namely supporting mothers to continue to eat regularly 3x/day and consume nutritious foods such as side dishes, fruit and vegetables, and increase drinking, namely 8-10 glasses/day so that the mother's digestion and milk production run smoothly.

   Evaluation: Mother has eaten rice 3x/day with fish and vegetables, drink
   8 glasses of water and 1 glass of sweet tea.
6. Advise mothers to get enough rest and sleep, namely 2 hours of naps during the day and 8 hours of sleep at night, as well as explain to mothers about the possible disturbance of sleep patterns due to the presence of a baby, so mothers can go to

sleep when the baby is sleeping so that the mother's stamina and health are maintained.

Evaluation: Mother understands and says she will do it as recommended.

7. Teach the mother how to breastfeed properly and correctly, namely clean the nipple with cotton and warm water, hold the baby where the head is on the mother's left elbow and the right hand supports the breast then take out a little milk from the mother's breast to induce the baby to suck, make sure the mother's stomach and stomach the baby sticks face to face, or the mother can lie down relaxed, place the nipple on the baby's lips and let the baby look for the mother's nipple so that the baby's mouth will open then put the nipple in the baby's mouth and the baby sucks, after breastfeeding burp so the baby doesn't vomit.

   Evaluation: The mother can do it well according to what the midwife taught her and the baby can suck and swallow well.

8. Counseling daily baby care, especially how to prevent hypothermic babies, namely by keeping the baby warm, including by placing the baby in a warm place, immediately changing wet baby cloths with dry and clean ones, and always putting baby hats on. In addition, teach mothers about umbilical cord care, namely not wrapping the umbilical cord or baby's stomach or applying liquid or any material to the umbilical cord, folding diapers under the umbilical cord, and if the umbilical cord is dirty, clean it carefully with DTT water and soap and Dry immediately using a clean towel.

   Evaluation: Mother understands the midwife's explanation regarding daily baby care, especially to prevent hypothermic babies.

Discussion

In this chapter, the author will describe the discussion of cases that have been taken about the gaps that occur in practices carried out in practice with existing theories, using the midwifery management approach according to Varney starting from assessment to evaluation. This discussion is intended so that conclusions can be drawn and problem solving from the gaps that occur so that it can be used as a follow-up in the implementation of effective and efficient midwifery care, especially in maternity patients with retained placenta.

1. Assessment

Assessment is the initial stage used in implementing midwifery care to patients and is a process of systematic data collection from various data sources to evaluate and identify the client's health status (Nursalam, 2009)

From the study, it was obtained subjective data for Mrs. W with retained placenta, the mother complained that she was worried because the placenta had not been born and the mother also said that in previous deliveries the mother had a history of retained placenta. And in objective data the mother's general condition is weak, contractions are weak, TFU is as high as the umbilical cord protruding and there is vaginal bleeding.

Retention of the placenta is the delay in delivery of the lacenta for half an hour after delivery of the baby. In other cases, recurrent retention (habitual retained placenta) may occur. (Manuaba, 2012).

Based on the subject data and object data, the authors found no gaps between theory and practice because at this stage the authors did not experience any difficulties. Data collection was carried out by interviewing the mother, observing and studying documentation from the MCH handbook and the patient's status and according to the patient's condition.

2. Basic Data Interpretation.

The interpretation of the data consists of midwifery diagnoses of problems and needs. According to Maryunani (2013), the problem that arises in mothers with retained placenta is anxiety about the situation they are experiencing. The needs that arise in mothers with retained placenta are information about their condition, information about the actions to be taken, moral encouragement and fluid fulfillment. In the case of Mrs. W, the midwifery diagnosis was Mrs. W, 29 years old with Retention of the Placenta and the problem that Mrs. W experienced was anxiety because the placenta was not born immediately for more than 30 minutes. To solve this problem, Mrs. W needed information about her condition. Information about actions to be taken moral encouragement, and liquid needs fulfillment.

In this case there is no discrepancy between theory and case because the established diagnosis is in accordance with the theory and in accordance with the subjective data and objective data that has been collected. The problems and needs needed are also in accordance with theory and practice.

3. Diagnose potential problems

The diagnosis of a potential problem that occurred in the case of Mrs. W aged 29 years GIIPIAO with retained placenta was Hemorrhagic Shock and infection, but Mrs W did not have hemorrhagic shock and infection because she received intensive treatment.

Diagnosing a potential problem is something for anticipation, prevention, if possible, waiting and full supervision and preparation for any event (Varney, 2004) and according to Sarwono (2012) mothers with retained placenta can experience hemorrhagic shock.

At this stage there is no gap between theory and practice in the field because since the mother has been diagnosed with retained placenta, the health workers have made a diagnosis of problems that might occur in the mother and are trying to anticipate problems the mother does not occur.

4. Anticipate potential problems

This action is taken if a potential diagnosis is found with the aim of anticipating problems that may arise in connection with the condition experienced by the mother (Varney, 2004). According to Rohani (2011) in cases of postpartum hemorrhage due to retained placenta, the anticipation is to check the general condition, consciousness, TTV, muscle tone, and amount of blood, then give oxytocin 20 units in

500 cc NS/RL with 40 drops per minute and give antibiotics, prophylaxis (ampicillin 2 grams IV/oral + Metronidazole 1 gram orally) and manual placenta removal.

Anticipation in practice is giving drips of oxytocin 20 units in 500 cc RL at a speed of 30 tts/minute and 30 units of ceftriaxone antibiotics, manual placenta administration, and giving oral therapy with amoxicillin 3x1, mefenamic acid 3x1, and microdinazole 3x1.

In this step the writer also found a gap between theory and practice. In theory, manual implementation of the placenta, anticipating infection prevention, is carried out with long gloves, but in practice, only using short gloves, so that infection transmission is still high.

5. **Action plan**

Action plans are made based on emerging diagnoses and monitoring patients to address problems and needs (Varney, 2010). In making an action plan, efforts are made to provide comfort to the mother and on the other hand to make observations. At this step the authors did not find any gaps between theory and cases in practice because the plans made in practice were no different from the plans in theory.

6. **Implementation**

Implementation is a process of solving clinical problems, making decisions and providing care (Varney, 2010). At this step the implementation is carried out with an action plan that has been made such as an intervention. At this step the authors found a gap between theory and practice because in implementing the treatment of retained placenta in theory, helpers must use long gloves while in practice, helpers (midwives) still use short gloves.

7. **Evaluation**

Evaluation is a comparison or overall plan of care from planning (Varney, 2010). In the theory of evaluation, it is hoped that the result will be that the placenta is complete, the general condition of the mother is good, the bleeding can be resolved and the mother feels comfortable. At this step the authors did not find any gaps between theory and practice because from the evaluation obtained in the field of practice, the mother's general condition had improved, bleeding had decreased, the placenta was born intact and the mother felt comfortable that the placenta had been born.

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CLOSING

Conclusion

1. In the study of the case of the mother in the third stage of labor in Mrs. W aged 29 years with retained placenta, subjective data was obtained with the main complaint, namely the mother felt worried because the placenta had not yet been born, the mother felt tired and weak and the mother said that in the first delivery she had done manual placenta. While objective data obtained general state data is weak,composmental Consciousness, TTV : BP : 110/70 mmHg,Q:78x/i, T : 36 0C,RR : 24x/i,umbilical cord does not extend at the vulva,bleeding ± 150 cc,placenta not delivered after 30

min, weak contractions,TFU : as high as the center. Based on this, there is no gap between theory and practice.

2. Interpretation of data in the case of mothers in the third stage of labor in Ny.W with retained placenta obtained an obstetric diagnosisMrs.W 29 years PIIAO third stage of labor with retained placenta. The problem that arises is that the mother is worried because the placenta has not yet been born and there is a lot of bleeding and what is needed is to inform the mother's condition, give the mother an agreement to do the placenta manual so that the placenta can be born immediately and stop the bleeding and keep the mother encouraged. Based on this, there is no gap between theory and practice.
3. Diagnose potential problems in casesthird stage in Mrs. W with retained placenta there would be hemorrhagic shock and infection, but this did not happen because the patient quickly got the right treatment.Based on this, there is no gap between theory and practice.
4. Anticipating potential problems made to Mrs. W 29 years old with retained placenta is to put infusion + oxytocin 20 units in 500 cc RL, give metergin 10 units/IM and antibioticsCeftriaxone 3cc and the placenta was done manually, but in anticipating the problem of infection was still high because long gloves were not provided in the manual procedure of the placenta. Based on this found a gap between theory and practice.
5. The action plan for Mrs. W aged 29 with retained placenta was in accordance with the patient's needs, namely performing manual placenta, administering oxytocin, administering antibiotics, medicamentosa, and administering IEC according to the needs of the mother.Based on this, there is no gap between theory and practice.
6. The delivery for Mrs. W 29 years with retained placenta was carried out in accordance with the action plan, but in carrying out the manual placenta, the midwife still used small gloves. Based on this, there is still a gap between theory and practice.
7. Evaluation of the mother in labor at Mrs.W 29 years with retained placenta found the results of a good general condition, awareness of compos mentis, TTV: BP: 110/70 mmhg, HR: 82x/i, RR: 20x/i, T: 36.5 0C, bleeding ± 500 cc, infusion has been installed, the placenta was born manually intact, drug therapy has been given, the mother feels happy and calm.Based on this, there is no gap between theory and practice.
8. In handling cases with retained placenta, there is a slight gap between theory and practice in preventing infection, namely in the use of handscoon.

Suggestions

1. For educational institutions

   In order to further improve the quality of education in the learning process both theory and practice. So that students can increase their knowledge and insight into pathological labor theories.
2. For clinics and health workers

It is hoped that clinics and other health workers can improve their services in handling cases of pathological childbirth, both in terms of infrastructure and health workers in health institutions.

3. For clients

It is expected that the client will increase awareness of the importance of carrying out pregnancy and childbirth checks assisted by health workers.

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