- **Modul**

Kegawatdaruratan Maternal Neonatal dan Basic Life Support

PROGRAM STUDI KEBIDANAN PURWOKERTO
PROGRAM DIPLOMA TIGA JURUSAN KEBIDANAN
POLTEKKES KEMENKES SEMARANG

TAHUN AKADEMIK 2024/ 2025

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VIS

"Menjadi Program Studi yang Menghasilkan ahli madya kebidananyang berbudi pekerti luhur dengan kompetensi unggulan deteksi dini kesehatan Ibu, bayi dan balita serta diakui internasional pada

MISI

1. Melaksanakan proses belajar mengajar sesuai kurikulum yang berlaku untuk membangun budi pekerti luhur dengan keunggulan deteksi dini kesehatan ibu, bayi dan balita serta mengikuti perkembangan ilmu pengetahuan dan tekhnologi (IPTEK)
2. Melaksanakan penelitian dibidang kesehatan khususnya pada deteksi dini kesehatan ibu, bayi dan balita serta mengupayakan publikasi setiap tahun
3. Melaksanakan pengabdian masyarakat dibidang kesehatan khususnya pada deteksi dini kesehatan ibu, bayi dan balita di setiap semester
4. Meningkatkan kualitas sumber daya manusia untuk melaksanakan tri dharma perguruan tinggi.
5. Mengupayakan lulusan agar dapat bekerja di Instansi bertaraf Internasional

MODULE I. BASIC LIFE SUPPORT

1. Theme Module : Basic Life Support
2. Subjects / Code : Neonatal Maternal Emergency and BLS / Bd. 5.026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :
7. Students are able to explain basic Life Support Basic
8. Module overview :
9. This module will specifically discuss Life Aid practicum Basic
10. Characteristics of students:

    This module is intended for fourth semester students of Study Program D III Midwifery Purwokerto PoltekkesKemenkes Semarang who have participated in learning and graduated in achieving the competency standardsof previous courses namely basic Biology and development, basic social and cultural sciences, basic humanconcepts, midwifery concepts , religion, citizenship, ethololegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, character education and noblecharacter, practice of basic midwifery skills, midwifery midwifery and newborn care, midwifery midwifery and medical science, character education and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, midwifery midwifery and medical science, character education and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, midwifery midwifery andpostnatal care breastfeeding, neonatal midwifery care, infants, toddlers and pre-school children h, public health, health promotion, clinical midwifery clinical practice.

11. Competency Targets :

    Students can provide basic Life Support gadar care
12. Indicators :

    Students can provide basic Life Support gadar care Learning
13. Material : Attached
14. learning strategies : Discussion, questions and answers, demonstrations and independent practice of patient stabilization skills
15. Learning support facilities: LCD, Computer

16. Procedures (Instructions Module Use):
    a. For students,
        - Students read and understand the learning objectives, practical assignments to be carried out, read references that are recommended.
        - Students practice skills and practices in accordance with the lecturers to conduct independent demonstrations of patient stabilization skills and students practice independent patient stabilization skills
17. Role of Teachers / Lecturers
    a. As a facilitator
    b. As a mediator
18. Method of evaluation: debriefing, post-test
19. Assessment Method: Value score of post-test, the response
20. Bibliography

    a. Maryunani Anik. 2013. Maternity and Neonatal Emergency Care. Jakarta: TIM.
    b. 2009. Emergency Care and Complications in Neonates. Jakarta: TIM.
    c. Lilis Lisnawati. 2009. Current Maternity and Neonatal Emergency Midwifery Care. Jakarta: TIM.
    d. Mochtar, Roestam. 2007. Synopsis of Obstetrics. Jakarta: EGC.
    e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.
    f. Wiknjosastro. 2007. Obstetrics. YBPSP

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BASIC LIFE ASSISTANCE

1. Definition

Resuscitation is an attempt to restore the function of the respiratory system, blood circulation and nerves that are disturbed to optimal function so that the term pulmonary resuscitation (CPR) appears. Cardiac pulmonaryresuscitation is divided into 3 stages, namely (1) basic life support (BHD); (2) further living assistance; (3) long-term living assistance.[3] Basic life support is

an effort to improve and / or maintain the airway, breathing and circulation as well as related emergency conditions. Basic life support consists of initial assessment, mastery of the airway, respiratory ventilation and chest compression.[6]

2. Pulmonary Resuscitation

As with all aspects of emergency medical emergencies, it is important to learn the basis of CPR systematically. If someone is found unresponsive, the following must be done quickly and sequentially.[5]

1. Assess the response. If unresponsive,
2. seek help by activating the local emergency medical service system.
3. Requesting a defibrillator (if applicable)
4. Position the victim and open the airway (maintain immobilization of thecervical spine if trauma has the potential to occur)
5. Assess breathing. If there is no breathing, then
6. provide breathing assistance.
7. Assess circulation. If there is no pulse,
8. start closed chest compression and continue ventilation. Use a defibrillatorif available

3. Early Action

After finding a collapsed victim, the first medical action to take is to assess the victim and determine whether the victim is actually responsive or not. However, before approaching a collapsed victim, environmental safety must be fully assessed whether it is a hazard or not. Security is very important.Before rescuers can help a sick or injured victim, make sure that the scene is safe for rescuers and those nearby, and gather initial impressions about the situation. Before the helper reaches the victim, continue to use the senses to get an initial impression of an illness or injury and identify what might be wrong. The information collected helps determine the direct action of the helper. Does the victim look sick? Is the victim aware or moving? Look for signs that might indicate life-threatening emergencies such as unconsciousness, abnormal skin color or life-threatening bleeding. If there is life-threatening bleeding, use available resources to control bleeding includingtourniquet if available and trained helpers.[7]

Once the victim has been reached, evaluate the victim's responsive level.[5] This is evident from the initial impression for example, the victim can talk toa helper, or the victim may complain, cry, make another sound or move. If thevictim is responsive, ask for the victim's consent, reassure the victim and tryto find out what happened. If the victim is silent and not moving, he may not be responsive. To check responsively, pat the victim's shoulder and shout, "Are you OK?" Use the person's name if the helper knows. Speak loudly. In addition, use AVPU to help determine the victim's level of awareness. AVPU consists of:[7]

A - *Alert*/ Beware: the victim wakes up, although it may still be confusedabout what happened.

V-Verbal / Voice: the victim responds to the excitement given by the helper. Therefore, the helper must provide a loud stimulus when making an assessment at this stage.

P - *Pain*: the victim responds to pain stimuli provided by the helper. Stimulation of pain can be given by pressing hard on the base of the nail or pressure by using the finger joints that are clenched in the sternum /sternum. However, make sure that there are no signs of injury in the area before doing so.

U - *Unresponsive*/ no response: the victim does not respond to all the stagesabove.

If the victim does not respond, it's time to seek help before starting chest ventilation and compression. In addition, efforts must be made to obtain a defibrillator. The time for special rhythm therapy, especially defibrillation for ventricular tachycardia or ventricular fibrillation, is very important for recovery of victims in heart attacks.

4. Airway Mastery

After assessing the victim's level of awareness, evaluate the victim's airway. Remember, if the victim is alert and talking, it means that the airwayis open.[7] Once the victim is unresponsive, seek help and assess the victim's

airway. This requires a supine position on a flat, hard surface with arms along the sides of the body, followed by opening the victim's airway. Unless trauma can be excluded, every victim movement must take into account the potential

for spinal cord injury. The victim is placed on her back, stabilizing the cervical spine by keeping her head, neck and body in a straight line. If for some reason the victim cannot be placed supine, consider using amaneuver*jaw thrust* from the lateral position to open the airway. Opening the airway correctly is a critical and potentially life-saving step. Common causes ofairway obstruction in the unconscious victim are oropharyngeal occlusion by the tongue and epiglottis weakness. With loss of muscle tone, tongue orepiglottis can be forced back to the oropharynx on inspiration. This can create the effect of a one-way valve at the entrance of the trachea, which causes obstruction of the airway as a stridor. After positioning the victim, the mouth and oropharynx must be examined for secretions or foreign bodies. If there is secretion, it can be removed by using oropharyngeal suction. Foreign objects can be removed using *finger sweeps* and then removed manually. After the oropharynx is cleaned, two basic maneuvers to open the airway can be tried torelieve upper airway obstruction, which consists of a *head tilt-chin lift* and*jaw thrust*. This maneuver helps open the airway by shifting the mandible and tongue mechanically.

1) Maneuver *Tilt-Chin LiftHead Thelift*

tilt-chinhead is usually the first maneuver try if there are no worries about injury to the cervical spine. *Head tilt is* done by gently extending the neck, which places one hand under the victim's neck and the other on the forehead and then puts the head in an extension position to the neck. This should place the victim's head in the "*sniffing position*" with the nose pointing up. This is done by carefully placing the hand, which has supported the neck to *head tilt*, under the symphysis of the mandible so as not to press on the soft tissue of the submental triangle and the base of the tongue. The mandible is then lifted forward until the teeth barely touch. This supports the jaw and helps tilt the head back.[5]

2) Maneuver *Jaw Thrust*

Jaw thrust is the safest method to open the airway if there is a possibility of cervical spinal cord injury. This helps maintain the cervical spine in a neutral position during resuscitation. The helper is positioned on the victim's head, puts his hand on the side of the victim's face, pinches his lower jaw at an angle, and lifts his mandible forward. Helper elbows can be placed on the surface where the victim is located then lift the jaw and open the airway with minimal head movements.[5]

5. Assessing Breathing and Starting Ventilation

Once the airway is cleared, an assessment of respiratory effort and air movement must be carried out. The helper should look for chest expansion and listen and feel the air flow. The simple act of opening the airway may be enough to restore spontaneous respiration. However, if the victim remains without adequate respiratory effort, further intervention is needed. Two slow breaths for 1 1/2 to 2 seconds each must be given. At this point, foreign body obstruction, as indicated by lack of chest rise or air flow in ventilation,requires efforts to relieve the obstruction. Agonal breathing in victims who have just had a heart attack is not considered to be adequate.5 Agonal breathing is isolated breathing or breathing that occurs without normal breathing in an unconscious victim. This breathing can occur after the heart stops beating and is considered a sign of a heart attack. If the victim shows agonal breathing, the victim needs to be treated as if he is not breathing at all. Intermittent positive pressure ventilation, if possible with oxygen-enriched air,must begin.[7]

a) Ventilation Techniques

There are a number of techniques for ventilation including mouth to mouth, mouth to nose, mouth to stoma, mouth to mask. A staging inspiration time of 1 1/2 to 2 seconds each must be given for 10 to 12 per minute, with enough volume to make the chest rise 800-1200 mL in most adults. Too much volume or too fast inspiratory flow will cause gastric distension, which can cause regurgitation and aspiration. Expiratory air has 16 to 17 percent FiO2. Additional oxygen should be given as soon as possible.[5]

- Mouth to Mouth

With the airway open, the victim's nose must be carefully covered with the thumb and index finger of the helper. This is to prevent the air from coming out. After taking a deep breath, the helper places his lips around the victim's mouth. The helper slowly exhales and gives the victim enough time to breathe passively, then repeat the procedure.[5]

When ventilating, if the chest does not rise after the first breath, open the airway again and try the second breath. If breathing is unsuccessful, return directly to pressure and check the airway for obstruction before attempting further ventilation. If a blockage occurs, remove it and try ventilation. With mouth-to-mouth ventilation, the victim gets an oxygen concentration of around 16 percent compared to ambient oxygen air concentrations of around 20 percent. Providing individual ventilation can help maintain this level of oxygen concentration. However, if the helper does not breathe in between the vents, the second vent may contain a

concentration of 0 percent oxygen with a high concentration of carbon dioxide (CO2).[7]

- Mouth to the Nose

  Sometimes in severe maxillary trauma, ventilation from mouth to nose is more effective. With the airway open, the helper lifts the victim's jaw and then closes his mouth. After taking a deep breath, the help placed his lips around the victim's nose and slowly exhaled.[5]

- Mouth to Stoma or Tracheostomy

  After laryngectomy or tracheostomy, stoma or tracheostomy becomes the victim's airway. As with the previous technique, breathing is given through a stoma tube or tracheostomy, and help slowly exhale.[5]

- Mouth to Face Mask

  The correct and safe placement of a face mask on the victim's face is important when using a face mask for ventilation. Either by *bag* or via mouth to face mask. Face masks must cover the victim's nose and mouth. Be sure to use what fits the victim's size and make sure to place and close the face mask properly before blowing the face mask. The helper places the thumb on the face mask that sits on the victim's nose and puts the index finger of the same hand on the face mask that sits on the victim's chin. The other three fingers of the same hand are then placed along the edge of the jaw. The face mask can then be closed tightly to the victim's face. Two hands can be used for this technique if a second helper is available. Ventilation is then carried out through the face mask.

b) Foreign Body Obstruction It is

important to recognize and be able to help someone with airway obstruction from foreign objects. A person who has difficulty due to an interrupted airway is likely to use a universal sign for airway obstruction, iethe victim will hold his neck with his hands. Foreign bodies can cause partial or total blockages.[7] With partial airway obstruction, air exchange can be adequate or inadequate. If the victim can talk, cough and exchange air, he must be encouraged to continue spontaneous efforts. Assistance such as activation of the local emergency medical service system must be obtained. If the air exchange becomes inadequate, marked by increased shortness of breath, weakness and cough. Worsening inspiration stridor, or cyanosis, direct medical intervention must be carried out. Inadequate air exchange from one of the partial or complete airway obstruction must be

treated equally. In an unconscious person, airway obstruction due to inadequate air flow and poor chest rise in ventilation efforts.[5]

c) Maneuvers in Obstruction

Maneuvers used to remove foreign body obstruction include the Heimlich maneuver (emphasis on the abdominal sub diaphragm), *chest thrust*, and *finger sweeps*. As a single method, *back blows are* no longer recommended for overcoming obstruction in adults. In conscious individuals, the Heimlich maneuver is a maneuver recommended for most adults to remove airway obstruction from solid objects. This is not useful for liquids. In an unconscious individual suspected of having foreign body aspiration, the recommended first step is *finger sweep*. If not, the victims are not aware of the recommended order Heimlich maneuvers up to five times, mouth open and do *finger sweeps*, then try ventilation. This sequence can be repeated as needed until the victim recovers or additional assistance arrives.[5]

- Heimlich Maneuver

  Explained by Dr. Heimlich in 1975. This maneuver creates an artificial cough through increased diaphragm and pressing air from the lungs. This canbe repeated several times. Every individual impetus must be done with the victim standing, sitting, or lying down, or can be managed alone. For the victim standing or sitting, the helper stands behind the victim and places the side ofthe thumb from the fist into the midline of the victim's abdomen just above the navel and far below the xiphoid process. While holding the fist with the other hand, the helper presses the fist into the victim's abdomen with a quick upward push. This is repeated until the obstruction comes out or the victim becomes unconscious. For the unconscious victim, the individual is placed on his back on a hard surface with a helper sitting astride the victim's thigh.[7] The heel of the hand is positioned in the midline directly above the victim's umbilicus, and the second hand is placed directly above the first. The helper then gives a quick upward push. For impulse given alone, the individual can use his own fist to send a push or lean on a solid object. Potential complications of the Heimlich maneuver include injury or rupture of the abdominal or thoracic viscera or regurgitation of stomach contents.[5]

- *Chest Thrust*

  This maneuver is used especially if a person is obese or in the late stages of pregnancy and the helper cannot reach around the victim's stomach to do a stomach push. To push the chest with the victim standing or sitting, the helper

stands behind the victim and places the side of the thumb from the fist against the victim's sternum, away from the costal margin and the xiphoid process. While holding the fist with the other hand, the helper pressed the fist against the victim's chest with a quick push back. This is repeated until the obstruction comes out or the victim becomes unconscious.[7] For the unconscious victim, the individual is placed on his back on a firm surface with the helper kneeling near the victim's side. The hand is placed in the same position as for chest compression, which is the lower sternu and pushes quickly.[5]

- *Finger Sweep*

  Maneuver is only used on victims who are not aware. Using the thumb and other fingers on the same hand, the helper catches the tongue and lower jaw and then lifts them up. This can eliminate partial blockage by lifting the tongue from the back of the throat. In another way, the helper then inserts her index finger into the back of the throat and uses an opening action in an effort to remove the foreign object manually. This must be done carefully so as not to push foreign objects deeper into the throat.5

6. Assessing Circulation and Early Compression

The carotid artery is generally the most reliable and accessible location to feel the pulse. The arteries can be found by placing two fingers on the trachea and then sliding them into the groove between the trachea and the sternocleidomastoid muscle. Simultaneous palpation of the two carotid arteries should not be done because this can block cerebral blood flow. The femoral artery can be used as an alternative place to feel the pulse. It can be found just below the inguinal ligament about halfway between the anterosuperior iliac spine and the pubic tubercle. If there is no pulse after 5 to 10 seconds, chest compression must begin.5 Untrained helper should provide RJP only compression (*Hands-Only*) with or without operator guidance for adult heart attack victims. The helper must continue the RJP only compression until the AED or helper with additional training arrive. In addition, if a trained helper is able to perform artificial breathing, he must add artificial breath in a ratio of 30 compression to 2 artificial breaths. The helper must continue the RJP until the AED arrives and is ready for use, the EMS provider takes over the care of the victim, or the victim starts moving

a. Chest Compression Techniques

After confirmation that a person is without a pulse, closed chest rhythmic compression must be performed. The victim is placed on her back on a hard surface with a helper beside her. The helper places the heel in a center line, the

hand at the bottom of the sternum, about 2 fingers above the xiphoid process. The heel of the hand must be parallel to the victim's body. The second hand is then placed on the first hand so that the two hands are parallel to each other. The fingers of both hands are intertwined. The arm must be straight and the elbows locked.5 The vector of compressive force must start from the shoulder of the helper and be directed downward; lateral strength will reduce the efficiency of compression and increase the likelihood of complications. The recommended depth of chest compression in adults is a minimum of 2 inches (5 cm), but not deeper than 2.4 inches (6 cm) in adults with a recommended chest compression speed of 100 to 120 / min (updated from minimum 100 / min). The amount of chest compressions given per minute during CPR is a major determinant of the RSOC condition (*return of spontaneous circulation*) and survival by neurological function which is good.8 For adult victims, CPR consists of 30 chest compressionsfollowed by 2 ventilation. With one helper, ventilation must be given after every 15 presses. With two rescue teams, ventilation must be provided after every fifth emphasis. It is important for rescuers not to rest on the chest between compressions to allow recoil between each pressure to allow blood to flow back to the heart following pressure.7 The

7. use of *Automated External Defibrillators (AEDs)*

Automated external defibrillators (AEDs) are safe and effective when used bylay people with minimal or no-trained training. It is recommended that AED programs for victims with OHCA be implemented in public locations where there is arelatively high chance of a heart attack victim (for example, airports and sports facilities). There is evidence of improvement in the survival rate of victims after a heart attack when rescuers do CPR and quickly use AED. Thus, fast access to the defibrillator is a major component in the maintenance system.[8] AED allows defibrillation several minutes before professional help arrives. The RJP provider must continue the RJP when installing the AED and during its use. The RJP provider must concentrate on following the voice immediately while the AED is speaking, specifically continuing the RJP as soon as instructed, and minimizing interruptions in chest compressions. Indeed, pre-shock and post-shock shock to chest compressions should be as short as possible. AED standards are suitable for use in children over 8 years.[1] For an AED to be effective, the helper must use it correctly by doing the following:[7]

a. Turn on first.

b. Make sure the patient's chest is exposed and dry. If necessary, remove or cut underwear that may be blocking. The cushion must be adhered to by the skin so that shock can be delivered to the heart.
c. Place the *pads* appropriate sizefor the patient's age on the chest. Place one *pad* in the upper right chest under the right clavicle to the right of the sternum, place *pad* the otheron the left side of the chest on the mid-axillary line a few inches below the left armpit.
d. Plug in the connector, and press the analyze button, if necessary.
e. Tell everyone to "clear" while AED analyzes to ensure accurate analysis. Make sure no one touches the patient during the analysis or surprise.
f. When "clear" is announced, the helper stops compression and hovers a few inches above the chest, but is still in a position to continue pressing as soon as the shock is delivered.
g. Observe the AED analysis and prepare surprises to be conveyed if advised. Ask the rescuer in a position ready to immediately resume the compression after the surprise is delivered or the AED suggests that the surprise is not indicated.
h. Send a surprise by pressing the surprise button, if indicated.

After a shock occurs, immediately start compression and do 2 minutes of CPR (about 5 cycles 30: 2) until the AED requests that the re-analysis, the patient shows a sign of the ROSC or a helper instructed by the team leader or more professional personnel to stop.

Don't wait for the AED to start RJP immediately after the message is shocking or there are no surprises.

Penyedia Layanan Kesehatan BLS Algoritma Serangan Jantung Pada Orang Dewasa—Pembaruan 2015

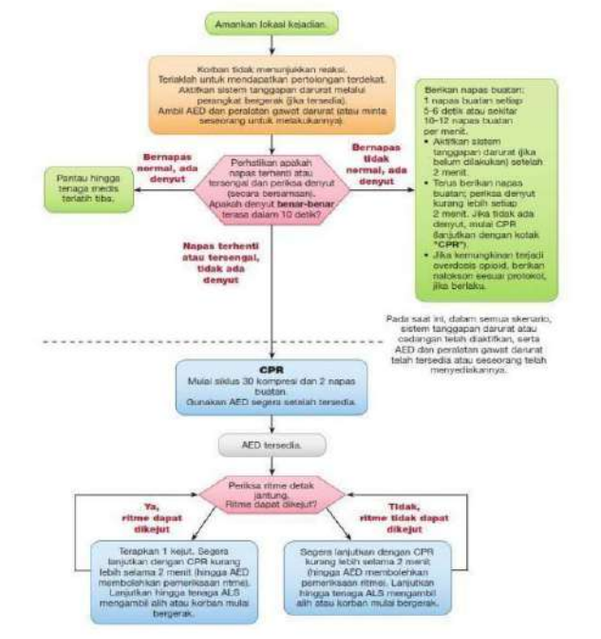

Diagram 1. Basic Life Support Flow

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OFSTUDENT :
DAY / DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODUL II. COMPLICATIONS THAT CAN OCCUR IN PREGNANCY

1. Theme Module : Complications Practicum Module that Can Occur in Pregnancy
2. Subjects / Code : Obstetrics Care for Neonatal Maternal Emergency and BLS / Bd. 5.026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain the initial handling of maternal and neonatal emergencies.
7. Module overview:

   This module will specifically discuss practicum maternal conditions at risk of emergencies by resuming the results of research journals and presentations: early handling of maternal and neonatal emergencies
8. Characteristics of students:

   This module is intended for fourth semester students of Department D III of Midwifery Purwokerto Poltekkes Ministry of Health Semarang who have participated in learning and graduated in achieving thecompetency standards of previous courses namely basic Biology and development, basic social and cultural sciences, concepts basic human, concept of midwifery, religion, citizenship, ethicolegal in midwifery practice, midwifery care, midwifery basic skills, communication in midwifery practice, medical science, character education and noble character, practice of basic obstetric skills, midwifery care and newborn , postpartum and breastfeeding midwifery care, neonatal midwifery care, infants, toddlers and preschool children, public health, health promotion, clinical practice of physiological midwifery.
9. Competency Targets:

   Students can explain the initial handling of maternal and neonatal emergencies
10. Indicator:

    Students are able to explain the initial handling of maternal and neonatal emergencies
11. Learning material : Attached
12. learning strategies: Resume the results of research journals and presentations: Initial handling of maternaland neonatal emergencies
13. Learning support facilities: LCD, Computer
14. Procedures (Module Usage Instructions):
    a. For
       1) Student Students read and understand the learning objectives, practical assignments to be carried out, read references recommended

2) Students practice skills and practices in accordance with the material. Resume the results of research journals and presentations: Abortion, KET, Mola Hidatidosa, Placenta Previa

b. Role of Teachers / Lecturers

1) As a facilitator

2) As a mediator

15. Method of evaluation: debriefing, post test

16. assessment Method: Value score of post-test, the response

17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b ..... 2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics.* YBPSP.

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EARLY CONCEPT OF MATERNAL AND NEONATAL AWARENESS CASES OFOBSTETRIK

A. BASIC PRINCIPLES

Emergency cases are obstetric cases which if not treated immediately will result in maternal and fetal death. This case is a leading cause of death of mothers, fetuses and newborns. The four main causes of death are:

- bleeding
- infection and sepsis
- hypertension and preeclampsia / eclampsia
- .labor (dystocia)

ObstructedObstructed labor occurs only during labor, while the other three causes can occur in pregnancy, labor and the puerperium. What is meant by bleeding here includes bleeding caused by injury to the birth canal, including uterine ruptura.

Clinical manifestations of emergency cases vary in a fairly wide range of

- cases. Bleeding can manifest from intangible bleeding, seeping, profus to shock
- Cases of infection and sepsis can manifest from the release of odorous vaginal discharge, green amniotic fluid, fever to shock .
- Cases of hypertension and preeclampsia / eclampsia can manifest from complaints of headache / dizziness, swelling, blurred vision, convulsions, tocoma / fainting / unconsciousness.
- The case of a stalled labor is more easily recognized, if the progress of labor does not take place according to the normal time limit, but the case of a stalled labor can be a manifestation of uterine rupture.

Considering the different clinical manifestations of obstetric emergency cases in a wide range, recognizing the case is not always easy to do, depending on knowledge, analytical and analytical skills, and experience of assistants. Errors or delays in determining a case can be fatal. In principle, when receiving every case that is faced must be considered an emergency or at least potentially emergency, until it turns out after the examination is finished the case is not an emergency case.

B. INITIAL ASSESSMENT

In determining the condition of obstetric cases faced whether in an emergency situation or not, a systematic examination must be conducted covering history, general physical examination, and obstetric examination. In practice, because a complete systematic examination takes a long time, even though the assessment must be done quickly, an initial assessment is carried out. The initial assessment is the first step to quickly determine obstetric cases that need help by identifying the complications (complications) they face.

The examination carried out in the initial assessment is as follows:

1. Check point of view
    - Assess the patient's consciousness: fainting / coma, convulsions, anxiety, lookin pain
    - Assess the patient's face: pale, redness, a lot of sweating

- Assess breathing: fast, shortness of breath
- Assess bleeding from genitals

2. Check touch
   - Skin: cold, fever
   - Pulse: weak / strong, fast / normal
   - Legs / lower limbs: swelling
3. Vital signs
   - Blood pressure, pulse, temperature and respiration

   The results of this initial assessment form the rationale for whether the case has complicated bleeding, infection, hypertension, preeclampsia / eclampsia, or shock. This rationale must be completed and strengthened by conducting a complete clinical examination, but before the complete clinical examination is completed, the steps to do first aid can be done according to the results of the initial assessment, for example found the condition of shock, first aid to overcome shock must have been done .

C. COMPLETE CLINICAL ASSESSMENT

A complete clinical examination systematically includes the following:

1. History

   Taking questions to the patient or family the following are some of the following and the answers are recorded in a medical record.
   - The main problem / complaint that is the reason why patients come to theclinic.
   - History of the disease / problem
   - First date of last menstruation and menstrual
   - history Current
   - pregnancy history Past pregnancy, childbirth and postpartum history including the condition of her child.
   - Family history of illnesses and diseases in the family
   - History of allergies to drugs
2. General physical examination
   - Assessment of general condition and awareness of patients
   - Penial vital signs (blood pressure, pulse, temperature, respiration)
   - Systematicbody systematically
   - examination of theexamination of the head and neck
   - Chest
   - examination Examination of the stomach (abdominal sign acute, free fluid inthe abdominal cavity)
   - Examination of the limbs (including edema of the lower limbs and legs)
3. Obstetric
   - examination of the vulva and perineum
   - Examination of the vagina
   - Cervical
   - examination of the uterus (magnitude, deformity, tumor etc.)
   - Adnexal

- examination His examination (frequency, duration) , strength, relaxation, symmetry and fundal dominance)
- Fetal examination:
    - Inside or outside the uterus
    - Number of fetuses
    - Position of the fetus
    - Presentation and decrease of presentation to what extent
    - Fetal position, moulage, and head of succedaneum
    - A small part of the fetus next to the presentation (hands, umbilical cordand etc.)
    - Congenital anomalies infetuses
    - estimatedfetal weight
    - fetus is dead or alive, fetal distress or

4. Pelvic examination
    - Ratings pelvic
        - promontory palpable or not
        - Size conjugate diagonalis and conjugate vera
        - Ratings linea inominata
    - Ratings hall pelvis
        - Ratings bone sacrum
        - penialian sidewalls
        - Penialain spina ischiadica (pointed or blunt)
        - size of the distance inter-spine ischiadicaArch
    - Assessment of pelvic lower entrance
        - pubic
        - assessment of coccyx (forward or not)
    - Assessment of presence of a birth canal tumor that prevents vaginal delivery
    - Pathological pelvic assessment Assessment of
    - feto-pelvic draw draw

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OFSTUDENT :
DAY / DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODUL III. COMPLICATIONS THAT CAN OCCUR IN PREGNANCY

1. Theme Module : Complications that Can Occur in Pregnancy
2. Subjects / Code : Obstetrics Care for Neonatal Maternal Emergency and BLS / Bd. 5.026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain Complications that Can Occur in Pregnancy.
7. Module overview:

   This module will specifically address practicum maternal conditions at emergency risk by making researchjournal results and presentations: Abortion, KET, Mola Hidatidosa
8. Characteristics of students:

   This module is intended forsemester students of D III Midwifery Study Program Purwokerto Poltekkes Ministry of Health Semarang which have participated in learning and passed in achieving the competency standards of previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, ethicolegal in midwifery practice, midwifery care of pregnancy, basic skills of midwifery, communication in midwifery practices, medical science, character education and noble character, practice of basic midwifery skills, midwifery and newborn midwifery, postpartum and breastfeeding midwifery care, neonatal midwifery care, infants, pre-school children and pre-school children, public health, health promotion n, physiological midwifery clinical practice.
9. Competency Targets:

   Students can explain Complications that Can Occur in Pregnancy
10. Indicators:

    Students are able to explain Complications that Can Occur in Pregnancy
11. Learning material : Attached
12. learning strategies: Resume research journal results and presentations: Abortion, KET, Mola Hidatidosa
13. Learning support facilities: LCD, Computers
14. Procedure (Module Usage Instructions):
    a. For Student
       1) Student Students read and understand the learning objectives, practical assignments to be carried out, read references recommended
       2) Students practice skills and practices in accordance with the material

       Resume the results of research journals and presentations: Abortion, KET, Mola Hidatidosa, PlacentaPrevia
    b. Role of Teachers / Lecturers
       1) As a facilitator
       2) As a mediator
15. Method of evaluation: debriefing, post test

16. assessment Method: Value score of post-test, the response
17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b ..... 2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics.* YBPSP.

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Maternity Emergency Pregnancy Care

In this topic, you will learn about maternal and neonatal emergencies in a young pregnancy that is very closely related to the well-being of the baby and can also threaten the mother. If a young pregnant woman is bleeding, it may be a sign of a possible pregnancy disorder. So that all three are a threat to the well-being of the fetus or the safety of the mother due to bleeding.

Emergency material in a young pregnancy

In the case of an emergency during a young pregnancy can be divided into three possibilities and this is a sign and danger that must be watched by women who are pregnant. Conditions that can cause danger signs are bleeding, which can be possible due to abortion, and an ectopic pregnancy is interrupted (KET) or molahydatidosa. However, all three have specific signs and symptoms and can be seen in the description below.

Abortion

Think about the possibility of abortion in women of reproductive age who experience late menstruation (with an interval of more than one month since the last menstrual period) and have one or more of the following signs: bleeding, abdominal stiffness, discharge as a product of conception, dilated cervix or dilated uterus smaller than it should

If abortion is a possible diagnosis, recognize and treat the complications immediately.

Types of abortion

After you have identified a case of bleeding in young pregnancy, you can read the chart below tofurther ease the incidence of abortion.

Diagnosis	Bleeding	Cervix	of the uterus	Other symptoms
Abortion iminens	Slight to moderate	Closed	accordance with age pregnancy	PP positive test Cramps
Abortion insipiens	Medium-many	Open	Match or small	Uterine software cramps uterus Software
Abortion inomplit	Bit-many	Open (software	Smaller than age pregnancy	Kram Out of tissue
Abortion complete	Little / not present	Soft (open or closed	Smaller than age pregnancy	Uteruslunak Little / nocramps Out of tissue uterine springy

Disrupted Ectopic Pregnancy Ectopic

pregnancy is the implantation (pregnancy) outside the uterine cavity. Most ectopic pregnancies in the tuba, only interrupted uterine a small portion in the ovary, abdominal cavity, cornu.Ectopic pregnancy is 4.5-19.7 / 1000 pregnancies.Some risk factors are: pelvic inflammation, ex ectopic, pelvic surgery, tubal anomalia, endometris and smokers.The classic trias symptoms are classic are: amenorrhea, abdominal pain and vaginal bleeding, where bleeding is found and severe pain in the lower abdomen. The uterus may be slightly larger,

and there may be a tumor mass in the adnexa. With intrauterine pregnancy ultrasound can be determined, otherwise we should look for gestational pockets or masses in the adnexa / cavity douglas. If an ultrasound bag of intrauterine gentasi (abdominal ultrasound) is found, usually the BhCG level is 6500 iu; or 1,500 if transvaginal ultrasound is performed. If such levels are found and no intrauterine pregnancy is found, look for extrauterine pregnancy.

Management

If the acute abdomen is found, the best course of action is KET hemostasis. The type of action to be taken must take into account the recovery of the function of the two tubes. If the mother still wants to get pregnant then do a salpingostomy. If the emergency condition, do not want to get pregnant again, irregular tears, infected, bleeding can not be controlled then do salpingectomy. In general, the following procedures will be carried out: Put infusion for substitution of fluid and blood loss

a. transfusion <6g%, If blood is not immediately available, perform autotransfusion duringoperative
b. Hfprocedures Perform partial salpingectomy or segmental excision followed by salpingorafi (as indicated)
c. Perform monitoring and postoperative care
d. Try infusion and transfusion after the patient's condition is stable.

In an ectopic pregnancy that has not been disrupted, hemodynamic conditions are stable, mass <4 cm and no intraabdominal bleeding, then consider giving MTX. MTX management success can reach 80%. Give 50 mg of MTX and observe BhCG which will decrease every 3 days. After 1 week, repeat the ultrasound, if the size of the pouch is fixedand pulsed, or B-hCG increases> 2 times in 3 days. Give the patient an explanation of the risks / success of conservative therapy and immediately do active therapy. If the patient is unable to recognize the danger signal, it is best to be hospitalized for observation.

In severe and massive intra-abdominal bleeding where replacements are not yet available and blood groups are scarce, consider autologous transfusion. Suck blood with a syringe of 20 ml, do filtering and collect in a blood flask containing anticoagulants, then transfusion back to the patient.

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OFSTUDENT :
DAY / DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODUL IV : COMPLICATIONS THAT CAN OCCUR IN PREGNANCY

1. Module Theme : Practicum Module Complications that Can Occur in Pregnancy
2. Subjects / Codes : Neonatal Maternal Emergency and BLS / Bd. 5026
3. Number of Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain complications that can occur in pregnancy.
7. Module overview:

   This module will specifically discuss practicum Complications that can Occur in Pregnancy by resuming the results of discussions about gadar kebianan care presentation: Plsenta previa and Placenta Solusiofourth
8. Student characteristics:

   This module is intended forsemester students of D III Midwifery Purwokerto Poltekkes Ministry of Health Semarang who has participated in learning and passed competency standards in previous courses, namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, etholoLegal in midwifery practice, midwifery care, basic midwifery skills , communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery care for newborns and newborns, postpartum and breastfeeding midwifery care, neonatal midwifery care, infants, toddlers and pre-school children, public health care at, health promotion, clinical practice of physiological midwifery.
9. Competency Targets:

   Students can explain Complications that Can Occur in Pregnancy
10. Indicators:

    Students are able to explain Complications that Can Occur in Pregnancy
11. Learning material : Attached
12. learning strategies: Resume of research journal presentations and presentations: Placenta previa and Placenta Solusio
13. Supporting learning facilities: LCD, Computer
14. Procedures (Module Usage Instructions):
    a. For Students
       1) Students read and understand the learning objectives, practical assignments to be carried out, read references recommended
       2) Students practice skills and practices in accordance with the material

          Conducting resume research journal results and presentations: Solusio Placenta, Atonia uteri, Retention of the placenta
    b. Role of Teachers / Lecturers

1) As a facilitator
2) As a mediator

15. Method of evaluation: debriefing, post test
16. assessment Method: Value score of post-test, the response
17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.
b ..... 2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.
c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.
d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.
e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.
f. Wiknjosastro. 2007. *Obstetrics*. YBPSP.

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Hesti Kurniasih, S.ST, M.Tr.Keb	Puji Hastuti Ahli (A). M.H.Kes	Dr. Wahn., S.ST., M.Kes
NIP. 199010272023212034	NIP. 19750222 200812 2 001	NIP. 196504231988032002

COMPLICATIONS THAT CAN OCCUR IN PREGNANCY

A. Placenta previa

During pregnancy, a woman's womb to grow and normal placenta will widen upwards, away from the cervix or cervical cancer. If it remains in the lower uterus or near the cervix, the placenta can cover part or all of the baby's birth canal. This condition is called placenta previa.

1. Symptoms of Placenta Previa

Placenta previa is a condition that is rarely experienced by pregnant women. But this risk must still be watched out because it can endanger the lives of mothers and babies in the womb. Pregnant women with placenta previa are shown to have a higher risk for bleeding before birth. The main symptom of this condition is bleeding without pain, which usually occurs in the last three months of pregnancy. But not all pregnant women with this condition will experience bleeding.

Bleeding generally occurs suddenly and blood volume can be large or small. The bleeding can stop on its own, but will reappear within a few days or a few weeks later. In addition, some pregnant women also experience contractions and pain in the back or lower abdomen. If you experience bleeding in the second or third trimester, you should immediately contact a doctor. Pregnant women who experience heavy bleeding are advised to immediately go to the hospital.

2. Risk Factors for Placenta Previa

The exact cause of placenta previa is unknown, but there are several factors that can increase the risk of pregnant women experiencing it. Some risk factors include:

- Having experienced placenta previa in a previous pregnancy.
- Had a cesarean section.
- Have had surgery on the uterus, such as a curette or removal of the myoma.
- 35 years of age or older.
- Never gave birth before.
- Had surgery on the uterus.
- Using cocaine.

3. Process of Diagnosis of Placenta Previa Placental

position will usually be known through an ultrasound examination at 18-21 weeks' gestation. If you have experienced bleeding during pregnancy, you will be advised to undergo transvaginal ultrasound. This process will provide more detailed imaging.

If you are positively diagnosed with placenta previa, your doctor will avoid routine vaginal physical examinations during pregnancy. This is done to reduce the risk of bleeding. You will also usually re-undergo an ultrasound process before giving birth to check the location of the placenta and the baby's heartbeat.

Placenta previa can be divided into 4 categories. This grouping is determined based on the position of the placenta and includes:

- Category 1 - the placenta is only implanted in the lower uterus without covering the cervicalopening.
- Category 2 - the placenta reaches the inner cervical opening, but does not cover it.
- Category 3 - the placenta partially covers the cervical opening.
- Category 4 - the placenta covers the entire cervical opening, including when the cervicalopening is open and dilated.

Pregnant women who experience placenta previa categories 1 and 2 are usually still allowed to give birth normally. Whereas placenta previa categories 3 and 4 will require a caesarean section.

4. Handling and Complications of Placenta Previa

Treatment for placenta previa usually involves as much rest as possible, blood transfusion if necessary, and caesarean section. The treatment step chosen depends on several factors, namely:

- Whether there is bleeding or not.
- Severity of bleeding
- The health condition of the mother and baby.
- Gynecology.
- Placental and baby position.

Pregnant women who do not or only experience a small amount of bleeding usually do not need hospital care, but must remain vigilant. Doctors will generally recommend resting at home. Sometimes there are even pregnant women who are advised to continue lying down and may only sit or stand if absolutely necessary. Having sex should also be avoided because it can trigger bleeding in patients with placenta previa. Likewise with sports. If bleeding occurs, pregnant women are advised to immediately go to the hospital before the bleeding gets worse.

Meanwhile, pregnant women who have experienced bleeding during pregnancy are advised to undergo the remainder of their pregnancy in the hospital from week 34. This step is recommended so that emergency assistance, such as a blood transfusion, can be given immediately if bleeding occurs again. A Caesarean section will also be performed once the pregnancy reaches a sufficient age, which is the 36th week. Before doing it, the mother will usually be given corticosteroids to accelerate the development of the baby's lungs in the womb.

For pregnant women with bleeding that does not stop, the doctor will recommend a cesarean section even though the age of the womb is not enough.

If left untreated, placenta previa can cause serious complications and be fatal to both mother and baby, such as heavy bleeding during childbirth and even afterwards.

B. SOLUSIO PLASENTA

Placental abruption is the release of the placenta from the inner uterine wall before labor, in whole or in part, and is a serious but rare complication of pregnancy. The placenta functions to provide nutrients and oxygen to the fetus, and is an organ that grows in the uterus during pregnancy.

Placental abruption can endanger the lives of the mother and the baby if not treated immediately. This is because the abruption of the placenta can cause severe bleeding for the mother, and the baby can lack nutritional and oxygen intake.

1. Symptoms of Placental

Abruption The gestational age of six months and above, especially a few weeks before the delivery process is the most frequent time experiencing placental abruption. Below are some of the symptoms of placental abruption that can occur:

- Back pain.
- Contractions are rapid.
- Bleeding in the vagina.

- The uterus hurts.
- Stomach ache.
- Lack of movement of the baby in the womb or not as usual.

2. Causes of Placental

abruption Until now the exact cause of placental abruption is unknown, but there area number of things that can increase the risk of placental abruption, namely:

- Women who smoke or who abuse drugs.
- Women over 40 years old.
- Women who have had placental abruption before.
- A woman who gave birth to twins.
- Women who have high blood pressure or hypertension.
- Women who have blood clotting disorders.
- Women who have experienced trauma to the abdomen, such as falling or getting hit.
- Amniotic fluid leaks or breaks out too early.

3. Diagnosis of placental

abruption To diagnose placental abruption, the doctor will initially perform a physicalexamination to check the uterine pressure, whether soft or hard. And blood tests or ultrasounds may be needed to help determine the cause of vaginal bleeding. High frequencyultrasound can also be used to see the uterus, but not always able to see the abruption of the placenta.

4. Complications of placental

abruption Solusio placenta can cause complications and endanger the lives of the mother and the baby. Pregnant women who suffer from placental abruption may experience blood clotting disorders and shock due to blood loss. In addition, complications due to abruptio placenta can also cause kidney failure or other organ failure. Bleeding may also occur after delivery. Hysterectomy or removal of the uterus may be done if the bleeding that occurs can not be controlled.

While complications due to abruption of the placenta in the baby being conceived can cause premature birth and lack of nutrition and oxygen intake. Even serious complications can cause a baby to be born dead.

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OF STUDENT :
DAY /DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODULE V. CASE OF JUSTED LABOR AND DISTOSIA SHOULDER

1. Module Theme : Practicum Module for Case of Labor and Shoulder Dystocia ShoulderS
2. Course / CodeCourse / Code : Neonatal Maternal Emergency and BLS/ Bd. 5.026
3. Number of Credit) : 3 credits (T: 2 credits, P: 1 credits)
4. Time allocation : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain cases of labor and shoulder dystocia
7. Overview of the module:

   This module will specifically discuss the practice of cases of labor births and dystocia later by conducting demonstrations and independent practice of childbirth assistance skills with shoulder dystocia (shoulder dystocia Mc. Robert).
8. Student characteristics:

   This module is intended for fourth semester students of D III Study Program in Midwifery PurwokertoPoltekkes Kemenkes Semarang who have participated in learning and graduated in achieving the competency standards of previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, etholoLegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery maternity care and newborns, midwifery and breastfeeding practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, postpartum midwifery and breastfeeding , neonatal midwifery care, infants, toddlers and pre-school children, public health, health promotion, clinical physiological obstetric practice.
9. Competency Targets:

   Students can explain cases of labor and shoulder dystocia
10. Indicator:

    Students are able to explain cases of labor and shoulder dystocia
11. Learning material : Attached
12. learning strategies: Discussion, questions and answers, demonstrations and independent practice of assisted delivery skills with shoulder dystocia (Mc. Robert) .
13. Means of supporting learning: LCD, Computer
14. Procedure (Instructions for Use Module):
15. The evaluation method: debriefing, post-test
16. assessment Method: Value score of post-test, the response
17. Bibliography

    a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.
    b ..... 2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.
    c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis of Obstetrics*. Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics*. YBPSP.

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CASE OF LABOR AND SHOULDER DYSTOCIA SHOULDERSHOULDER

A. PR O LO N G ED LAB O R

term old parturition, some also call it partis kasep and partus abandoned. Labor in primi usually takes 5-6 hours longer than multi. If labor lasts a long time, complications can occur both for the mother and for the child, and can increase maternal and child mortality.

Old parturition is labor that lasts more than 24 hours on primary, and more than 18 hours on multi.

Kasep parturition, according to Harjono, is the last phase of a parturition that is jammed and lasts too long so that symptoms such as dehydration, infection, maternal fatigue, and asfiction and fetal death in the womb (KJDK). (Mochtar, 1998).

Old parturition is labor with no head loss> 1 hour for nulliparous and multiparous. (Sarwono, 2008)

Most of the old parturition shows an elongation of stage I. As for the cause, namely, the cervix fails to open fully within a reasonable amount of time. (Harry, 2010) We

must also differentiate from parturition, which is a delivery with an adequate breast that does not show progress on cervical opening, head fall and rotation during the last 2 hours.

Labor in older primi is usually longer. There is a general opinion that labor often occurs at night, this is due to the fact that labor usually lasts for 12 hours or more, so the beginning and end of labor is usually at night. The incidence of prolonged labor according to research is 2.8-4.9%.

1. **The etiology**

   of the old parturition The causes of the old parturition are multicomplicated and of course depend onsupervision while pregnant, good childbirth assistance and management.

   Factors causing include:

   a. Abnormalities of the location of the fetus
   b. Breechal
   c. location Latitude
   d. disorders Pelvic abnormalities

      Can be caused by: growth disorders, bone and joint disease, vertebral column disease, inferior extremity abnormalities. Pelvic abnormalities can cause pelvic narrowing.
   e. abnormalities

      HisHis abnormality in strength or nature causes obstacles in the birth canal that are common inevery labor, cannot be overcome so that labor experiences obstacles or congestion.
   f. The parturition leader is wrong The
   g. fetus is large or there are congenital abnormalities.
   h. Hydrocephalus
   i. Macrosemia
   j. Anensefalus
   k. Kembarsiam
   l. Primitua
   m. Stomach hanging, multi grande.
   n. Amniotic DiseaseParturial

2. **Symptoms of OldClinics**

   a. In mothers

      Restless, fatigued, increased body temperature, sweating, rapid pulse, rapid breathing, and meteorismus. In the local area high bandle circles are often found, vulva edema, cervical edema, amniotic fluid smelling, meconium is present.
   b. In infants
      1) the fetal heart rate is fast / intense / irregular, even negative.
      2) Amniotic fluid is meconium, thick greenish, smelly.
      3) Large caput sucsadaneum Great
      4) head moulage
      5) Death of the Fetus in the Womb (KJDK)
      6) Intra Partal Fetal Death (KJIP). (Mochtar, 1998).

3. **Signs and Symptoms of OldThe**

   a. Pregnancymother looks tired and weak.
   b. Irregular but strong contractions.

c. Cervical dilatation is slow or does not occur.
d. There is no decrease in the lowest part of the fetus, despite adequate contractions.
e. molding sutures overlap and cannot be repaired.

4. Effects of OldPartus

a. Mother's:

Effects for mothers are decreased morale, fatigue, dehydration, acidosis, infection and risk of uterine rupture. The need for surgical intervention warns mortality and morbidity. Ketoacidosisby itself can result in poor uterine activity and prolong labor.

b. Fetus:

Effects for the fetus include trauma, acidosis, hypoxic damage, infection and increased perinatal mortality and morbidity.

5. Handling of Old / Stalled Partial Reference

a. Objective

Knowing immediately and appropriate handling of emergencies in old / stalled parturition

b. Standard Statement

Midwives accurately and early signs and symptoms of parturition are stuck. Midwives will take appropriate actions, start treatment, refer mothers and / carry out appropriate emergencymanagement.

c. Results

1) Early identification of symptoms and signs of prolonged labor and appropriate actions
2) Appropriate and thorough use of partographs for all mothers during labor
3) Decrease maternal / infant mortality / morbidity due to old parturitionin labor
4) Mothers receive prompt and appropriate obstetric emergency care

6. Prerequisites

1) Midwives are called if the mother is alreadystart heartburn / rupture of membranes
2) Midwives have been trained appropriately and skillfully to:
3) use partographs and labor records
4) do checks to properly
5) identify things that cause prolonged / obstructed labor to
6) identify abnormal presentations (other than vertex / head-back presentation) pregnancy
7) appropriate important management for prolonged and stalled labor.
8) Tests for DTT delivery assistance include several pairs of sterile gloves and catheters / DTT.
9) Availability of equipment for safe and safe delivery assistance, such as running water, clean soap and clean towels, two clean towels / warm cloth (one for m dry the baby, another for later use), sanitary napkins, and placenta. Midwives use gloves.
10) Availability of partograph and Mother's Card, KIA book. Partographs are used appropriately foreach mother in labor, all treatments and observations are recorded on time. Appropriate action is taken in accordance with the findings recorded in the parograph.

7. TheProcess

Midwifemust:

a) Monitor and record periodically the condition of the mother and fetus, his and the progress of labor on the partograph and delivery record. Complete all components on the partograph carefully at the time of observation.
b) If there is a deviation in the progress of labor (for example, the alert line on the partograph is reached, his is too strong / fast / very weak, the pulse is weak and fast, or the FHR becomes fast / irregular / slow), then palpate the uterus carefully to detect symptoms and signs of pathological retraction / bandl circle
c) Keep the mother in order to get good hydration during labor, encourage the mother to drink frequently.
d) Encourage the mother to take a walk, and change position during labor and birth. Don't let the mother lie on her back during labor and birth.

e) Ask mothers to urinate frequently during labor (at least every 2 hours). A full bladder will slow the baby down and make the mother uncomfortable. Only use a catheter if you can't urinate yourself and the bladder can be palpated. Only use a rubber catheter. (be careful when installing a catheter, because the urethra is easily injured in the old parturition / jam)

f) Observe the signs of parturition jam and prolonged by palpating the abdomen, assessing fetal decline, and checking in, assessing fetal infiltration, and cervical opening at least every 4 hours during the latent and active phase of labor. Record all findings on the partograph. See standard 9 to see all observations needed for partographs.

g) Always observe signs of maternal distress or fetal distress, refer quickly and appropriately if this happens

h) Wash hands with soap and clean running water then dry until completely dry with a clean towel every time before and after contact with patients (nails must be cut short and clean). Use DTT /sterile gloves for all internal checks. Always use aseptic techniques when checking in.

Carefully examine the vagina and its condition (if the vagina is hot / symptoms of infection and dry / symptoms of membranes are minimal, then indicate the mother is in danger). Also check the location of the fetus, the opening of the cervix and whether the cervix is thin, tense, or has edema. Try to determinethe position and degree of decline of the head. If there are abnormalities or if the alert line on the partographis crossed, prepare an appropriate reference.

a) Appropriately refer to the latent phase of labor that extends (0-4 cm): lasts more than 8 hours.
b) Refer appropriately to the active phase that extends, less than 1cm / hour and the alert line on thepartograph has been crossed.appropriately for the second stage of
c) Referlabor elongated:
d) 2 hours of straining for primiparous
e) 1 hour of straining for multiparous
f) If there are signs and symptoms of labor, fetal distress, or danger signs to the mother, then the mother is laid to the left side and give IV RL fluid. Refer to hospital. Help your mother to keep the mother in good condition. Explain to the mother, husband / family what happened and why the mother needs tobe taken to the hospital.
g) If uterine rupture is suspected (his sudden stop or severe shock), then refer immediately. Give antibiotics and IV fluids (RL), usually given ampicillin1 g IM, followed by giving 500mg every 6 hours IM, then 500mg orally every 6 hours after the baby is born
h) If the condition of the mother / baby is bad, and the opening of the cervix is complete, then the birth aids infants with vacuum extraction (see standard 19)
i) If delays occur after birth (dystocia of the baby):
j) Perform an episiotomy
k) With the mother lying supine, ask the mother to fold both thighs, and bend the knee toward the chest as close as possible (ask two people to help, maybe)
l) Use DTT gloves / sterile

B. Shoulder DystociaShoulder dystocia is the

1. UNDERSTANDING SHOULDER DISTOSIAattachment of the fetal shoulder and cannot be born after the fetal head is born. Besides shoulder dystocia can also be defined as the inability to give birth to the shoulder with the mechanism or the usual way.

2. RISK FACTORS FOR SHOULD DYSTOSIA
Pelvic deformities, gestational diabetes, postmature pregnancy, history of labor with short shoulder andmaternal dystocia.

a. Maternal
   - Pelvic anatomic abnormalities
   - Gestational diabetes
   - Postmature pregnancy
   - History of shoulder dystocia
   - Short maternal body

b. Fetal
   - Alleged macrosomia

c. Problems with labor
   - Assisted vaginal delivery (forceps or vacuum)
   - "Protracted active phase" in the

   firstlaborstage of• "Protracted" at the time II

   delivery

   Shoulder dystocia often occurs in labor with middle cunam or in interruption of the first stage and /or second stage of labor.

3. SIGNS AND SYMPTOMS OF SHOULDER DISTOSIA

a. In the normal delivery process the head is born through an extension movement. In shoulderdystocia the head will be pulled inside and cannot experience normal external rotation.
b. Head size and cheek shape indicate that the baby is fat and big. Likewise with the parturient body posture which is usually also obese.
c. Attempts to rotate the outside axle, lateral flexion and traction did not deliver the shoulder.

4. DIAGNOSIS OF SHOULDER DISTOSIA

a. The fetal head can be born but remains near the vulva.
b. The chin is attracted and presses the perineum.
c. A pull on the head fails to give birth to a trapped shoulder behind the symphysis pubis.

5. Complications of shoulder dystocia

a. Complications Maternal
   1) bleeding after childbirth
   2) fistula rectovaginal
   3) Simfisiolisis or diathesis, with or without a "transient femoral neuropathy
   4) 'tearperineum stage III or IV
   5) Rupture uteri
b. Complications Fetal
   1) Brachial plexus palsy
   2) fractures clavicle
   3) Fetal death
   4) Fetal hypoxia, with or without damage neurololgis permanent
   5) fractures of the humerus

6. MANAGEMENT OF SHOULDER DYTOSIA

Recommendations from the American College of Obstetricians and Gynecologists (2002) for the management of patients with a history of shoulder dystocia in past labor: A

a. careful evaluation of estimated fetal weight, gestational age, maternal glucose intolerance and the degree of fetal injury in previous pregnancies is needed.
b. The advantages and disadvantages of performing a SC procedure must be discussed properly with the patient and his family.
c. American College of Obstetricians and Gynecologists (2002): Research conducted with evidence based methods concludes that: Most cases of shoulder dystocia cannot be predicted or prevented and SC actions performed on all patients suspected of containing fetal macrosomia are excessive attitudes, except when it is suspected that there are pregnancies that exceed 5000 grams or the suspected fetal body weight contained by diabetics is more than 4500 grams.

SKILLS OF SKILLS Mc.

ROBERTOBJECTIVE STUDENT BEHAVIOR

Students can:

- Prepare tools and materials for Mc. Robert
- Carry out the procedures and steps of Mc. Robert correctly

INSTRUCTIONS

- Prepare materials and tools needed
- Read and learn worksheet / job sheet that has been provided
- Follow the instructors
- Report work following completion of the exercise

SAFETY

- Focus and concentration on the action procedure
- Before the procedure, bring the tools and materials
- Use tools appropriate with its use
- Ergonomic equipment layout
- Use PPE
- Pay attention to septic and aseptic techniques in carrying out procedures

EQUIPMENTS

- Bed / table
- Clean water and soap for hand washing
- Small towels
- Partus set
- Heacting set
- Gloves Gloves
- Chlorine solution 0.5%
- Placental

MATERIAL

materialPhantoom Pelvic delivery, oxytocin and a 3 cc syringe

CHECKLIST HANDLING DISTOSIA LABOR HANDLING WITH THE MC. ROBERT

NO	ITEM	VALUE		
		0	1	2
A.	**ATTITUDE**			
1.	**Welcome the client politely and friendly** 1. Not done 2. Greeting without looking at the client 3. Greeting by looking at the client			
2.	**Introducing yourself to the client** 1. Not done 2. Introducing yourself as a midwife without mentioning the name 3. Introducing yourself as midwives by name while shaking hands / giving a friendlytouch to the client			
3.	**Responding to client's reaction** 1. Not responding indifferently 2. Responding to client's reaction but not responding appropriately, imperfectly 3. Responding to client's reaction appropriately and politely			
4.	**Confidence** 1. Stunned, not make eye contact and voice less clear 2. Look in a hurry and hesitant, lack of confidence 3. Look calm and do with confidence			
5.	**Tested to maintain client privacy** 1. Not done 2. Give an opportunity to clients to submit complaints but do not respond properly 3. Give opportunities to clients to submit a complaint and immediately m make well			
B.	**CONTENT**			
6.	**Wearing PPE (apron, hat, glasses, mask, shoes)** 1. Not donenot done 2. Done butDone 3. well			
7.	**Washing hands with technique 7 steps** 1. Not done 2. Done but not 7 steps 3. Done well			
8.	**Wearing gloves** 1. No do 2. Done but pay less attention to aseptic 3. Done well			
9.	**Position the mother by lifting and pulling the two thighs of the mother as far as possible toward the mother's chest** 1. Notnot done 2. Done butDone 3. well			
10.	**Do episiotomy to widen the birth canal** 1. Not done 2. Done but not to do with Good 3. Do well			
11.	**Encourage the mother to push when there is her, while both thighs pulled as far as possible towards the chest** 1. Not done 2. Pushed but not lifted feet 3. Well done			
12.	**Pulling the steep head down to give birth to the anterior shoulder with the biparietal hand position (avoid excessive pressure on the baby's head because it might be injured him) and at the same time ask for assistants to apply a little suprapubic pressure gently** 1. Not done 2. Done but not quiteRight 3. Done			

13.	**After the anterior shoulder is born, deliver the posterior shoulder by pulling the head steeply upward with the position of the biparietal hand** 1. Not Done 2. Done but not according to axis birth canal 3. Well done			
14.	**Giving birth to a full body baby propped up prop.** 1. Do not support and run 2. Done only one 3. Done well			
15.	**Clean the tools and soak in a 0.5% chlorine solution.** 1. Not done 2. Cleansing but not immersing in a chlorine solution 3. Done well			
16.	**Washing gloves into 0.5% chlorine solution and removing it in reverse** 1. Not done 2. Immediately soaking without washing first 3. Well done both			
17.	**Washing hands with the 7-step technique** 1. Not done			
	2. Done but not seven steps 3. Done well			
18.	**Removing PPE** 1. Not Done 2. Done but not complete 3. Done well			
19.	**Tells the results of the action to the mother and husband / family.** 1. Not done 2. Done but not clear 3. Done well			
C.	**TECHNIQUE**			
20.	**Tested systematically** 1. Not done 2. Performed partially and not sequentiallysequential 3. Performedactions			
21.	**Tested applying infection prevention techniques** 1. Not done 2. Applying infection prevention techniques not quite right 3. Applying infection prevention techniques with Appropriate			
22.	**Tested carrying out communication during action** 1. Not carried 2. out Conducting communication but in a language that is not easily understood bythe client 3. Carry out communication using language that is easily understood by the client			
23.	**Tested documenting the results of actions well** 1. Not done 2. Documenting the results of actions but not complete 3. Documenting all results actions with date, time, name and signature of the executor			
	TOTAL SCORE ENTIRE: **46**			

END VALUE = $\frac{\Sigma \text{ Score}}{46}$ x 100

MODULE VI. BREECH DELIVERY

1	Module Theme	:	Breech Delivery
2	Subject / Code	:	Neonatal Maternal Emergency and BLS / Bd. 5.026
3	Total Credit	:	3 Credit (T: 2 Credit, P: 1 Credit)
4	Time Allocation	:	1 x 170 minutes
5	Semester / TA	:	IV / 2018/2019
6	Objectives	:	After attending this lecture students are able to practice handling Stabilizationand referral to maternal gadar cases
7	Overview module	:	this module explains how to aid delivery of breech
8	Characteristics of Students	:	Students already have theories about maternal conditions that are at risk in emergency
9	Target Competence	:	Students are able to practice the handling of aid delivery breech
10	Indicators of Achievement	:	Students are able to make the handling of aid delivery breech
11	Learning materials	:	Stabilization and referral cases for neonatal gadar
12	Learning Strategies	:	● Students are divided into 4 groups with each supervisor who is a member of the lecturer of the Maternal and Neonatal Emergency Care. ● Each breech delivery assistance and documentation ● After seeing the demonstration, each student practices accompanied by each supervisor. ● At the end of learning the Maternal and Neonatal Emergency Subjects,students are tested using a checklist.
13	Learning Support Facilities	:	Tools needed to manage hemorrhagic pot partum: breech birth assistance
14	Procedures (if needed)	:	Checklist (checklist) attached breech birth aid
15	Evaluation Method	:	Observation
16	Assessment Methods	:	Redemonstration
17	Bibliography	:	1. MOH (2005), *24-hour Comprehensive Emergency Neonatal Obstetric Service Management Guidelines at the District / City Level* 2. Drew David (2002), *Resucitation of the Newborn: A Practical Approach*, Butterword Heinemann 3. Elizabeth Gilbert (2003), *Manual of High Risk Pregnancy and Delivery*, Mosby

Prepare by	Examined by:	Authorized by:
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BREECH PRESENTATION

A technique of spontaneous breech rescue (spontaneous BRACHT)

1. Relief begins after the buttocks appear on the vulva with a cross section of about 5 cm.
2. Inject 5 oxytocin units with the aim that with 1–2 of his subsequent rapid phase in vaginal breechspontaneous labor will be completed.
3. By using hand-coated, damp cloth, breech fetus is held so that both thumb rescuers are at the back of the thigh and four other fingers are on the buttocks of the fetus *(Figure 1)*
4. At the time the mother meneran, do motion directing the child's back to the mother's abdomen(hyperlordotic motion) until both feet of the child are born.
5. After the foot is born, the grip is changed in such a way that both thumbs are now in the back of thegroin and the four fingers are on the fetal waist *(figure 2).*
6. With this grip, the hyperlordosis movement is continued (motion closer to the child's buttocks on themother's abdomen) slightly towards the left or towards the right in accordance with the child's back position.
7. The hyperlordosis movement continues until the mouth-nose-forehead and the entire head of the childare born.
8. At the time of delivery of the head, the assistant applies supracymphysis pressure in the direction of the birth canal in order to maintain the fetal head's flexion position.
9. After the child is born, care and further assistance is performed as in spontaneous vaginal delivery at the presentation of the back of the head.

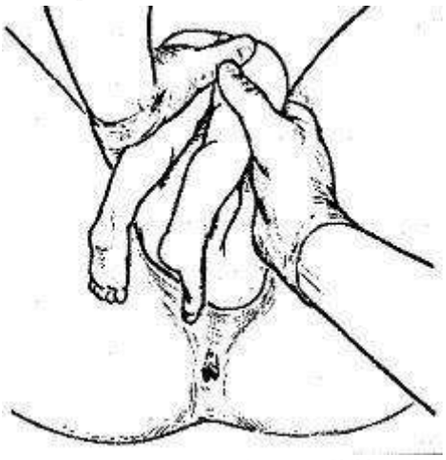


Figure 1: Child's pelvic grip in spontaneous labor Bracht

Cause of child death:

1. Talipusat is trapped during the fast phase.
2. Intracranial hemorrhage due to sudden decompression during childbirth in the second slow phase.
3. Vertebral collumna trauma.
4. Talipusat prolapse.

PARTIAL EXTRACTION IN LABORS OF THE PERVAGINAL SUNGSANG (MANUAL AID)

Consists of 3 stages: The

1. buttocks until the umbilicus is born spontaneously (in frank breeches).
2. Delivery of the shoulders and arms is assisted by a helper.
3. Head delivery is assisted by a helper.

SHOULDER AND ARM LABOR

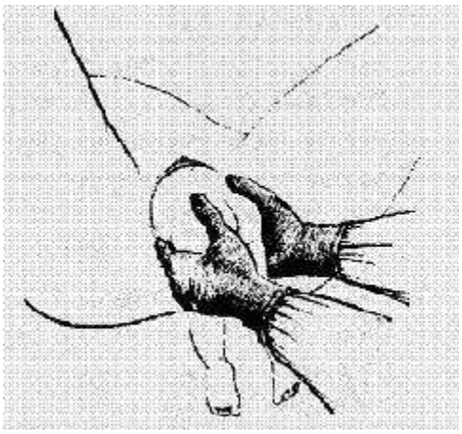


Figure 3 "Femuro Pelvic"vaginal breech delivery assistance Thehelping

1. grip ongrip on the child's pelvis is such that thethumb is adjoining the os sacrum with both index fingers on the anterior superior iliac crest; thumb on the sacrum while the other fingers are in front ofthe groin (figure 3).
2. Steep traction is carried down to meet obstacles (obstacles) the birth canal.
3. Then the shoulder can be born using one of the following methods:
   a. Lovset.
   b. Classic.
   c. Müller.

1. Shoulder delivery by the way

LOVSET.Principle:

Rotate the body of the fetus in a half circle (180^0) clockwise and counterclockwise while doing steep traction downward so that the shoulder which was originally behind will be born in front (under symphysis).

This can occur because:

- The existence of pelvic inclination (the angle between the top door of the pelvis with the pelvic axis)
- There is a curvature of the birth canal where the front wall is longer than the arch of the sacrum wall on theback

So that at any time the posterior shoulder will be in a lower position than the shoulder position anterior

Technique:

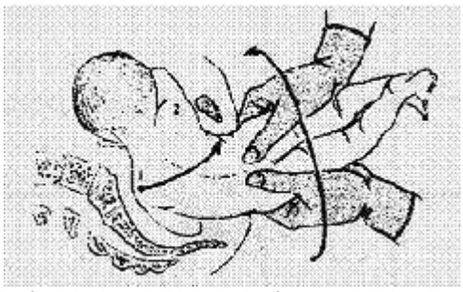


Figure 4 The fetal body is held with the femuropelvik handle.

Do *the 180^0 while performing traction steep downward so that the rear shoulder into the front shoulder underthe arch of the pubis and may be born*

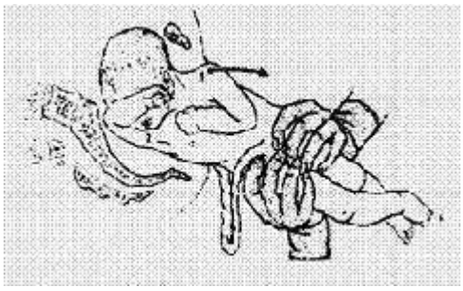
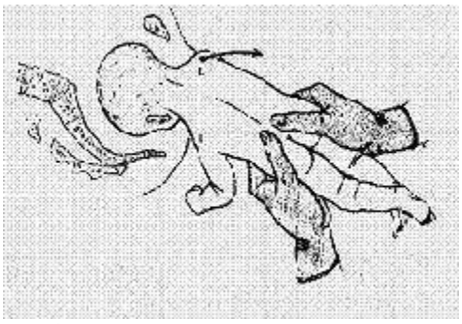


Figure 5 As he carried traction steep bottom, fetal body rotated 180^0 direction opposite to the front shoulder into thefront shoulder under the arch of the pubis and may be born



Pictures 6 The fetal body is rotated back 180^0 in the opposite direction so that the back shoulder returns to the frontshoulder under the arcus pubis and can be born

Advantages of shoulder delivery by **Lovset** :

a. Simple technique.
b. Almost always can be done without looking at the position of the fetal arm.
c. The possibility of intrauterine infection is minimal.

2. Shoulder delivery by the way CLASSIC

a. Also known as DEVENTER technique.
b. Give birth to the back arm first and then give birth to the forearm under the symphysis.
c. Selected if the shoulder is stuck at the pelvic upper door.

Principle:

Give birth to **the back of the forearm** first (because the back of the sacral space / sacrum is relatively wider in front of the front of the pelvis) and then give birth to the forearm under the arcus pubis

Technique **:**

Figure 7 Childbirth childbirth in the shoulders technique CLASSICFigure 8

Childbirth childbirth in the childbirth technique CLASIK

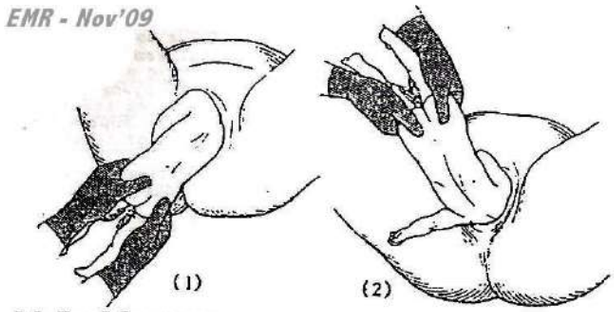
1. Both ankles are held with the tip of the right hand finger of the helper between the ankles of the child, then elevated as far as possible by moving the child's abdomen close mother's stomach.
2. The helper's left hand is inserted into the birth canal, the middle finger and forefinger of the left hand goes along the shoulder to find the cubital fossa and then with amotion *"rubbing face" fetus "*, The posterior arm under the child is born.
3. To give birth to the forearm, the grip on the ankle of the fetus is changed.

With the right hand of the helper, the fetal ankle is held and while being carried down steep traction performs movements as if "bringing the fetal back close to the mother's back" and then the forearm is born the same way.
When in this way at No. 3 on the front arm is difficult to be born, then it is turned into an arm sleeve behind by:
Advantages: Generally always be done on the shoulder delivery
Disadvantages: The entry of the hand into the birth canal infection increases the risk of

3. labor shoulder by way of MüELLER Give

- birth to the shoulder and forearm first under the symphysis through extraction; followed by givingbirth to the back arm behind (front of the sacrum)
- Selected if the shoulder is stuck at the Pelvic Lower Door

Figure 9 (left) Giving birth to the front shoulder with extraction on the buttocks and if necessary assisted



Muller Manuver
(1) Badan bayi ditarik ke bawah sampai bahu depan lahir, kemudian
(2) badan ditarik ke atas kanan sampai bahu belakang lahir

with the index finger of the right hand to remove the front arm
shoulder delivery techniques MüELLER method:

1. Buttocks are held with a "femuropelvik" handle.
2. With this grip, a steep steep traction is carried out on the body of the fetus until the front shoulder is born(*figure 9*) under the arcus pubis and then the front arm is born by connecting the lower front arm.
3. After the shoulder and forearm are born, the ankle is clasped with the right hand and elevation and traction are carried out (*figure 10),* traction and elevation in the direction of the arrow) until the back shoulder is born by itself. If it cannot be born on its own, a link is made to give birth to the child's backarm (inset in *figure 10*).

The advantage of using this technique is because the helper's hand does not go too far into the birth canal, the risk of infection is reduced.

HEAD OF LABOR:.How to **MOURICEAU** (Viet - Smellie)

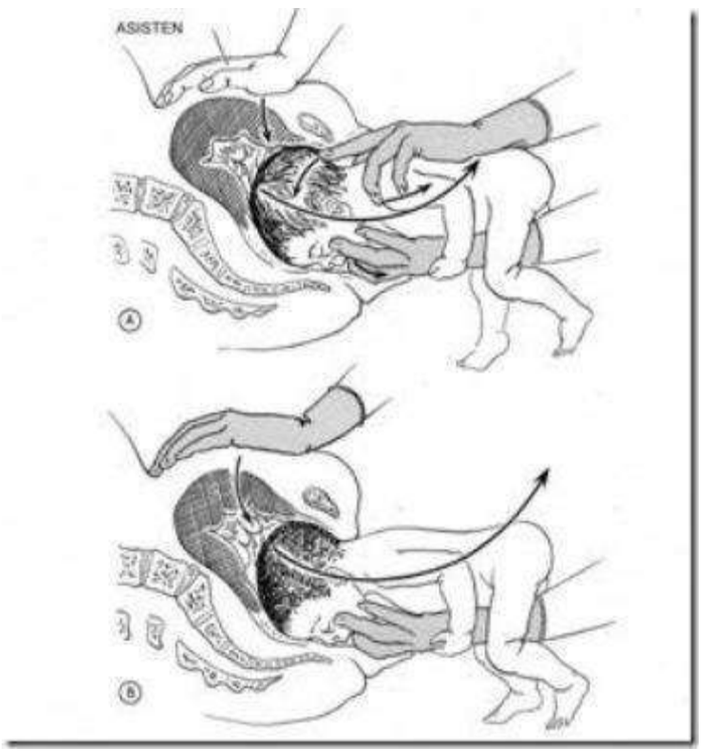


Figure 16 Mouriceau Techniquehelping

With ahand in the direction facing the face of the fetus, the middle finger is inserted into the mouthof the fetus and the index finger and ring finger are placed on the fossa canina.

1. The child's body is placed on the child's arm, as if the child is "riding a horse".
2. The back of the child's neck is stuck between the index and middle fingers of the other hand.
3. Assistants help by applying pressure on the suprasymphysis area to maintain the fetal head's flexion position.
4. Steep down traction is mainly carried out by the neck at the neck.

INSTRUCTIONS WORK SKILLS breech deliveries

OBJECTIVE BEHAVIOR OF STUDENTS

Students are able to:

1. Prepare tools and materials for maneuver manually placenta
2. Implement procedures and manual steps placenta properly

INSTRUCTIONS

1. Prepare materials and tools needed
2. Read and learn worksheet / job sheet that has been provided
3. Follow the instructions instructor
4. Report work following completion of the exercise

SAFETY

1. Focus and concentration on the action procedure
2. Before the procedure, bring the tools and materials
3. Use tools according to their usefulness
4. Letakaan equipment is ergonomically
5. Use APD
6. Note the technique of septic and aseptic in performing the procedure

mATERIALS aND EQUIPMENT

1. bed / desk
2. Air clean and soap for hand washing
3. small towels
4. Partus set
5. Heacting set
6. gloves
7. 0.5% chlorine solution
8. Points placenta
9. Phantoom Deliveryand placenta,
10. oxytocin and 3 cc syringe

ASSESSMENT CHECKLIST & FORMATBRACHT AID DELIVERY TECHNIQUE

NO	ITEMS ASSESSED	VALUE		
		0	1	2
A	**ATTITUDE**			
1	**Say hello to the client and introduce yourself** 0. Not done 1. Just say hello or just introduce yourself 2. Say and introduce yourself			
2	**Explain the purpose and procedure to be done** 0. Not done 1. explain the purpose or procedure 2. explain the purpose and procedure			
3	**Respond to the patient's reaction** 0. Not respond 1. Observe the patient's reaction but do not respond appropriately 2. Observe the patient's reaction and respond appropriately			
4	**Confidence** 0. Test nervously, not make eye contact 1. Look in a hurry and hesitant 2. Look calm and do it with confidence			
5	**Maintain patient privacy** 1. Not done 2. Maintain privacy by speech **or** demonstrate closing the door / sampiran 3. Maintain privacy by speech **and** demonstrate closing the door / sampan			
	CONTENT			
6	**Positioning the patient in a dorsal recumbent** 1 Not done 2 Doneimperfectly 3 Done perfectly			
7	**Using PPE (apron, hat, mask, footwear)** 0 Tid ak used 1 PerfectlyPerfectlyused 2 used			
8	**Washing hands 7 steps** 1 Not done 2 Done imperfectlyPerfectly 3 DoneDone			
9	**Put a clean duk / towel on mother's abdomen** 0not done Done1 Done imperfectly. 2 Perfectly done			
10	**Notifies the opening mother is complete and helps the mother in the lithotomy position and leads when she is having *** 0 Not done / done imperfectly2 Performed perfectly			
11	**Immediately after the buttocks are born, the buttocks are gripped with both thumbs in line with the thighs , the other fingers holding the pelvic area *** **0** Not done / done imperfectly 2. Performed perfectly			

12	**Thighs gripped, buttocks should not be pulled, do not intervene and follow the fetal discharge process according to the birth canal curve *** 0 Not done / done with imperfect2 Performed perfectly			
13	**Loosen the umbilical cord after birth of the abdomen and part of the chest (after repositioning both hands to help grip the fetal buttocks) *** 0 Not done / done imperfectly2 Done perfectly			
14	**Perform fetal hyperlordosis at the time of the inferior scapula appear under symphysis (by following ge anterior rotation rack ie the fetal back near the mother's abdomen without traction) adjusted to the birth of the fetal body** *** 0** Not done / done imperfectly 2 Performed perfectly			
15	**Move upward until the chin, mouth, nose, forehead and baby's head are born born *** 0 Not done / Done imperfectly2 Done perfectly			
16	**Placing baby on mother's belly, wrap baby in warm towel** 0 Not done 1 Done imperfectly 2 Done perfectly			
17	**Washing hands in 0.5% chlorine solution and removing gloves hands in reverseand washing hands** **0** Not doing **1** Done imperfectly **2** Done perfectly			
C	**TECHNIQUE**			
18	**Tried to carry out procedures systematically** 0 Not done 1 Done in sequence 2. Done in sequences			
19	**Tried to apply infection prevention techniques** 1 Not done / applied PI techniques Inappropriate 2. Applying PI techniques appropriately			
20	**Tested to carry out commun ication during action** 0 Not done 1 Using language that is not easy to understand 2 Carry out communication using language that is easily understood by patients			
21	**Tested to document the actions and results, complete with date, time, signature and name** 1 Not done 2 Done incompletecompletely 3 DoneDone			

TOTAL SCORE = 42

END VALUE = $\frac{\Sigma \text{ score}}{42}$ **x 100**

TESTER NAME: .....

MODULE VII. COMPLICATIONS THAT CAN OCCUR IN LABOR STAGE III AND IV

1. Module Module : Practicum Module Complications that can occur in labor stage III and IV
2. Course / Code : Obstetrics Care for Neonatal Maternal Neonatal and BLS / Bd.5.026
3. Total Credits : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain the complications that can occur in the third and fourth stages of labor.
7. Module overview:

   This module will specifically discuss the practicum Complications that can occur in the third and fourthstages of labor by conducting demonstrations and independent practice of KBI and KBE skills.
8. Student characteristics:

   This module is intended for fourth semester students of D III Study Program in Midwifery Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and graduated in achieving the competency standards of previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, etholoegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery maternity care and newborns, midwifery and breastfeeding practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, postpartum midwifery and breastfeeding , neonatal midwifery care, infants, toddlers and preschoolers, public health, health promotion, physiological midwifery clinical practice.
9. Competency Targets:

   Students can explain Complications that can occur in the third andlabor
10. Indicator:

    Students are able to explain the complications that can occur in the third and
11. Learning material : Attached
12. fourth stages offourth stages of learninglearning strategies: Discussion, questions and answers, demonstrations and independent practice of KBI skills and KBE
13. Learning support facilities: LCD, Computer
14. Procedures (Module Usage Instructions):

    a. For

    1) Student Students read and understand the learning objectives, practical assignments to be carried out, read references recommended
    2) Students practice skills and practices in accordance with the material

    lecturers conduct demonstrations and students practice independent skills KBI and KBE

    b. Role of Teachers / Lecturers

    1) As a facilitator

2) As a mediator

15. Method of evaluation: debriefing, post-test
16. assessment Method: Value score of post-test, the response
17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.
b ..... 2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.
c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.
d. Mochtar, Roestam. 2007. *Synopsis of Obstetrics*. Jakarta: EGC.
e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.
f. Wiknjosastro. 2007. *Obstetrics*. YBPSP.

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ATONIA UTERINE

A. Definition of Atonia Uterine

Atonia Is obstetric bleeding caused by the failure of the uterus to contract adequately after birth (Cuningham, 2013: 415).According to JNPK-KR (2008), the *definition of uterine atony is* a condition where the myometrium cannot contract and the blood comes out of the placental implantation site and becomes out of control. Uterine atony is the most common cause of early postpartum hemorrhage (50%), and is themost frequent reason for postpartum hysterectomy. Uterine contractions are the main mechanism for controlling bleeding after delivery.

B. Etiology

Uterine overdistence is the most frequent risk factor for uterine atony. Uterine overdistence can be caused by multiple pregnancy, fetal macrosomia, polyhydramnios, fetal abnormalities, abnormalities of uterine structure, or distension due to accumulation of blood in the uterus either before or after the placenta is born.

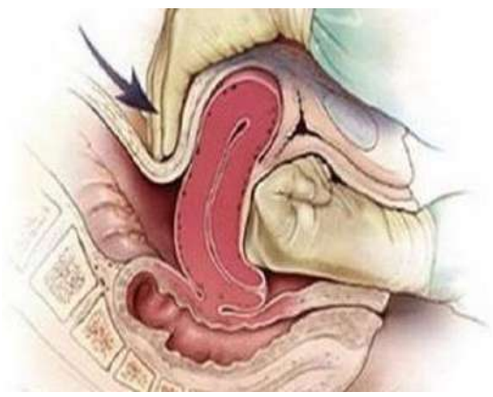
The leadership of the third stage is wrong, by massaging and pushing the uterus. Weak myometrial contractions are the result of fatigue due to prolonged labor or labor that requires a lot of energy, age is too young and too old, especially if given stimulation to the mother. Besides the influence of drugs that can cause contraction inhibition such as: halogenated anesthetics, nitrates, nonsteroidal anti-inflammatory drugs, magnesium sufate and nipedipine.

Mothers with poor general condition, anemia, or chronic disease. Other causes include: low placental location, prolonged parturition (bacterial toxin) (chorioamnionitis, endometritis, septicemia), hypoxia due to hypoperfusion or uterine couvelaire in placental abruptio.

C. Diagnosis of Uterine Atonia

Unless intrauterine and intravaginal blood accumulation may not be identified, or in some cases of uterine rupture with intraperitoneal bleeding, diagnosis of post partum hemorrhage should be easy. Temporary distinction between bleeding due to uterine atony and from laceration is established based on the condition of the uterus. If bleeding continues even though the uterus is strongly contracted, the cause of bleeding is most likely laceration. Fresh red blood also suggests laceration. To ensure the role of laceration as a cause of bleeding, careful inspection of the vagina, cervix, uterus must be carried out.

Sometimes bleeding is caused by both atonia and trauma, especially after a large operative delivery. In general, there must be an inspection of the cervix and vagina after each delivery to identify bleeding due to laceration. Anesthesia must be adequate to prevent discomfort during the examination. Examination of the uterine cavity, cervix, and entire vagina must be performed after extraction of the buttocks, internal podical version, and vaginal delivery in women who have had cesarean section. The same thing applies to excessive bleeding during the second stage of labor (Cunningham, 2013).



D. Management of Uterine Atonia

1. Wear high-level or sterile disinfection gloves, gently insert obstetrics (bringing together the five fingertips) through the introitus and into the mother's vagina.
2. Check the vagina and cervix. If there is an amniotic membrane or blood clot in the uterine cavity, this may cause the uterus to not be able to contract fully.
3. Clench the inner hand and place it on the anterior fornix, press the anterior wall of the uterus, towards the outer hand that holds and pushes the posterior wall of the uterus towards the front so that the uterus is pressed from front to back.
4. Press the uterus firmly between your hands. This uterine compression puts direct pressure on open

blood vessels (former implantation of the placenta) in the uterine wall and also stimulates the myometrium to contract.

5. Evaluation of success:
   If the uterus contracts and bleeding decreases, continue KBI for two minutes, then slowly release your hands and monitor the mother closely for stage four.
   If the uterus is contracting but bleeding is still ongoing, double check the perineum, vagina and cervix for lacerations. If so, suture immediately to stop the bleeding. If the uterus does not contract for 5 minutes, teach the family to perform external bimanual compression (KBE) and then perform further uterine atony management steps. Ask the family to start preparing references.
6. Give 0.2 mg ergometrin IM or misoprostol 600-1000 mcg per rectal. Don't give ergometrin to motherswith hypertension because ergometrin can raise blood pressure.
7. Using a large diameter needle (size 16 or 18), attach the infusion and give 500cc Ringer Lactate solution containing 20 units of oxytocin.
8. Put on sterile gloves or high-level disinfection and repeat the KBI.
9. If the uterus does not contract within 1 to 2 minutes, immediately refer the mother because this is not a simple uterine atony. Mothers need emergency measures at a referral health facility that is capable of performing operations and blood transfusions.
10. While bringing the mother to the place of reference, continue the KBI action and intravenous fluids untilthe mother arrives at the place of reference. The first 500 ml infusion is finished within 10 minutes. Give an additional 500 ml / hour until it arrives at the reference site or until the amount of liquid infused reaches 1.5 L and then continue in the amount of 125cc / hour. If the infusion fluid is not enough, infuse
    500 ml (the second bottle) infusion fluid with moderate droplets and supplemented with oral administration for rehydration.

KBI SKILLS / KBE SKILLS

OBJECTIVE STUDENT BEHAVIOR
Students can:

1. Prepare tools and materials for KBI maneuversKBI
2. Implementprocedures and steps correctly

INSTRUCTIONS

3. Prepare materials and tools needed
4. Read and study the work sheet / job sheet provided
5. Follow instructions instructor
6. Report Report work results after completing the exercise

SAFETY WORK

1. Focus your attention and concentration on the procedure of action
2. Before the procedure, bring the tools and materials together
3. Use the tools according to their use
4. Ergonomic equipment layout
5. Use APD
6. Pay attention to septic and aseptic techniques in performing procedures

EQUIPMENTS

- Bed / table
- Clean water and soap for hand washing Small hand
- towels
- Partus set

1. Heacting sets
2. Gloves
3. Chlorine solution 0.5%
4. Placenta place

MATERIALS
PhantoomHip, Uterus, oxytocin and syringe 3 cc

CHECKLIST & FORMAT ASSESSMENT OF INTERNAL BIMMAL COMPRESSION

NO	POINT	VALUE		
		0	1	2
A.	**ATTITUDE**			
1.	**Greet politely and friendly and memo patient exclusion** 1 Not done 2 Greeting only without positioning the patient 3 Greeting and positioning the patient			
2.	**Introducing themselves to the patient** 1 Not done 2 Introducing yourself as a midwife without naming name 3 Introducing yourself as a midwife by saying the name while shaking hands			
3.	**Responding to the patient's reaction** 1 Not respondingresponding 2 Responding to the patient's reaction butnot responded appropriately 3 Responds to the patient's reaction appropriately			
4.	**Confidence** 1 Tested nervous, did not make eye contact and voice unclear 2 Looked in a hurry and hesitated 3 Look calm and do with confidence			
5.	**Tested giving empathy to patients** 1 Not done 2 Giving opportunity for patients to submit complaints but do not respond properly 3 Provide opportunities for patients to submit complaints and immediately respond properly.			
B.	**CONTENT**			
6.	**Using PPE (apron, hat, mask, footwear)** 0 Not done 1 Done imperfectly. 2 Do perfectly			
7.	**Wear short gloves on both hands** . Not done . Doneimproperly . Done properly			
8.	**To massage the uterus with the left hand to remove the blood clot and / or membranes of the uterus** . Notdone . Done improperly . perfectly Guide			
9.	**Emptying the bladder** . Not done . Done improperly . Done perfectly			
10.	**Removing short gloves and replacing with long gloves on the right hand *** 1 Not done or done incorrectly 2 Done perfectly			
11.	**Inserting the right hand obstetically into the lumen vagina *** . Not done or done improperly . Done perfectly			

12.	**Changing the obstetric hand into a fist with thumb in fist *** . Not done or done incorrectly . Done perfectly			
13.	**Putting the back plate of the index finger to the little finger on the anterior fornix or *** . Not done or done improperly . Done perfectly			
14.	**Pushed the lower uterine segment towards the anterior cranio *** . Not done or done incorrectly . Done perfectly			
15.	**Try the outside hand to cover the back of the uterine corpus as much as possible *** . Not done or done improperly . Done perfectly			
16.	**Conducting uterine compression by bringing the palm of the external hand close to the fist in the anterior fornix for 5 minutes *** . Not done or done incorrectly . Done perfectly			
17.	**Release pressure while evaluating uterine contractions and bleeding (right hand is not removed) *** . Not done or done improperly . Done perfectly			
18.	**After the uterus has contracted, maintain KBI for 2 minutes** 1 Does not maintain the position of the uterus 2 Maintain a position without being evaluated whether the contractions are good ornot immediately released 3 Maintaining contractions until the uterus creaks ntraction good by saying "this mother has a hard stomach, have you felt mules? "			
19	**Remove the hand slowly by first turning the fist into an obstetric hand** 1 Removing the hand without changing the fist 2 Removing the hand too quickly 3 Changing the fist into an obstetric hand and removing it slowly			
20	**Tools are cleaned soaked in chlorine solution 0, 5%** 1 Not donedone 2 Done notPerfectly 3 Done Perfectly			
21	**Washing hands into chlorine solution then removing gloves in reverse** 1 Not done 2 Done imperfectly 3 Done Perfectly			
C.	**TECHNIQUE**			
22	**Systematically** 1 tested Not done 2 Performed partially and not sequentiallysequential 3 Performedactions			
23	**Tested applying techniques infection prevention** 1 Not done 2 Applying infection prevention techniques incorrectly 3 Applying PI techniques appropriately			
24	**Maintaining patient privacy** 1 Not done 2 Maintaining privacy by speech or demonstrating closing doors / sampiran 3 Maintaining privacy with uca pan and demonstrate closing the door / sampiran			

25	**Tested carrying out communication during the action** 1 Not carried 2 out Conducting communication but using language that is not easilyunderstood by the patient 3 Carry out communication using language that is easily understood by the patient			
26	**Tested documenting the results of the action properly** 1 Not done 2 Documenting the results of the action without implementing identity 3 Documenting the entire result of the action with the date, time, name andsignature of the implementing			
	ENTIRE TOTAL SCORE: **52**			
	FINALSCORE			

SCORE FINAL= $\frac{\text{Score}\Sigma}{52}$ x 100

CHECKLIST & ASSESSMENT FORMAT COMPRESSION EXTERNAL BIMANUAL

NO	ITEMS ASSESSED	VALUE		
		0	1	2
A.	**ATTITUDE**			
1 .	**Greeted by polite and friendly as well as positioning the patient** 1 Not done 2 without positioning Greetspatients 3 Greetsand patient positioning			
2.	**Introduce yourself to the patient** 1 Not done 2 Introducing himself as a midwife without naming 3 Introducing himself as a midwife in the name conn shaking hands			
3.	**Responding to the patient's reaction** 1 Not responding 2 Responding to the patient's reaction but not responding appropriately 3 Responding to the patient's reaction appropriately			
4.	**Confidence** 1 Tested to be nervous, not making eye contact and voice is unclear 2 Looked in a hurry and hesitated 3 Look calm and calm do it with confidence			
5.	**Provide empathy for the patient** 1 Not done 2 Give a chance to patients to submit complaints but do not respond properly 3 Give opportunities to patients to submit complaints and immediately respond properly.			
B.	**CONTENT**			
6.	**Using PPE (apron, hat, mask, footwear)** 1 Not done 2 Done imperfectly.			

	3 Done perfectly			
7.	**Wear short gloves on both hands** 1 Not done 2 is done improperly 3 done correctly			
8.	**To massage the uterus with the left hand** 1 not done 2 done improperly 3 done perfectly			
9.	**Emptying the bladder** 1 not done 2 done incorrectly 3 doneperfectly			
10.	**Place one hand on top of the symphisis and the other hand covers in such away that the two hands meet each other *** 1 Not done or done incorrectly 2 Performed perfectly			
11.	**Conducting uterine compression by bringing both hands together *** 1 Not done or done incorrectly 2 Done perfectly			
12.	**Release pressure while evaluating uterine contractions and bleeding *** 1 Not done or done incorrectly 2 Done perfectly			
13.	**After the uterus has contracted release hands slowly** 1 Not done or done incorrectlycorrectly 2 Donempurna			
14	**Tools cleaned up soaked in chlorine solution 0.5%** 1 Not done 2 PerfectlyPerfectly 3 donedone			
15.	**Washed hands in chlorine solution then released gloves in reverse** 1 Not doneworked 2 PerfectlyPerfectly 3 done			
C.	**TECHNIQUE**			
16 .	**Tested systematically do** 1 not do 2 doing most of the action and not sequentially 3 in seriesTaking action			
17.	**Tested implement infection prevention techniques** 1 Tidakdilakukan 2 applying less appropriate infection prevention techniques 3 applying infection prevention techniques with proper			
18.	**patient privacyMaintain** 1 not done 2 privacy Maintainingwith speech or demonstrating just close the door / sampiran 3 Maintain privacy by speech and demonstrate closing the door / sampiran			
19.	**Tested carrying out communication during action** 1 Not carried 2 out Carry out communication but by using language that is not easily understoodby patients 3 Carry out communication i using language that is easily understood by the patient			
20.	**Tested documenting the results of the action properly**			

	1 Not done 2 Documenting the results of the action without the identity of the executor 3 Documenting all results of the action with date, time, name and signature of theimplementer			
	TOTAL SCORE ENTIRE: **40**			

FINAL VALUE = $\frac{\Sigma \text{ Score}}{40} \times 100$

MODULE VIII. COMPLICATIONS THAT CAN OCCUR IN LABOR STAGE III AND IV

1. Module Module : Practicum Module Complications that can occur in labor stage III and IV
2. Course / Code : Obstetrical Care for Neonatal Maternal Emergency and BLS / Bd. 5. 026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Allocation of time : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to practice handling complications that can occur in labor stage III and IV.

   Retention of placental residue and birth canal injury III / IVfourth stages of
7. Module overview:

   This module will specifically discuss practicum Complications that can occur in the third andlabor
8. Student characteristics:

   This module is intended for semester IV students of D III III Midwifery Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and passed in achieving the competency standards of previous courses, namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, etholelegal in midwifery practices, midwifery care of pregnancy, basic obstetric skills, communication communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery and newborn midwifery, postpartum and breastfeeding midwifery care, neonatal midwifery care, infants, toddlers and pre-school children, public health, health promotion , kebida clinical practice physiological.
9. Competency Targets:

   Students can complete cases Complications that can occur in the third andlabor
10. Indicator:

    Students are able to complete cases Complications that can occur in the third and
11. Learning material : Attached
12. fourth stages offourth stages of learninglearning strategies: make resumes of research journal presentations and presentations: Rupture uteri , Pre Eclampsia / Eclampsia, Asphyxia
13. Learning support facilities: LCD, Computer
14. Procedures (Module Usage Instructions):

    a. For students,

       1) students read and understand the learning objectives, practical assignments to be carried out, read references recommended by
       2) students, discuss discussions about gadar case studies

    b. Role of Teachers / Lecturers

       1) As a facilitator
       2) As a mediator
15. Method of evaluation: debriefing, post-test

16. assessment Method: Value score of post-test, the response
17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b .....2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis of Obstetrics*. Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics*. YBPSP.

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PLASENTA RETENTION

Retention of the placenta is that the placenta has not been released for more than half an hour. This condition can be accompanied by heavy bleeding, meaning that only a portion of the placenta has been released so it requires immediate manual placental action. If placental retention is not followed by bleeding it is necessary to note that there is a possibility of adhesive placenta, placenta accreta, placenta inkreta, placenta perreta. (Manuaba (2006: 176).

Incarcerated placenta means that the placenta has been released but is left in the uterus due to contractions in the lower part of the uterus or uterus so that the placenta is retained in the uterus. (Manuaba (2006: 176).

Based on the above understanding it can be concluded that the retention of the placenta is the unborn placenta within half an hour after the fetus is born, this condition can be followed by heavy bleeding, meaning that only a portion of the placenta has been released so that it requires immediate manual placental action

A. Types of placental retention:

1. Placenta Adhesive: Strong implantation of a chorion juxotype placenta causing failure of the physiological separation mechanism
2. Placenta Acreta: Implantation of the placental chorion junction to enter part of the myometrium layer
3. Placenta Inkreta: Implantation of the chorion of the placental chorion that penetrates the muscle layeruntil it reaches the uterine lining of the
4. uterus.Prumpa placenta: Implanted the junction of the placenta corion that penetrates the serous liningof the placenta in the placental layer ding of the uterus to theperitoneum
5. incarcerated placenta: The retention of the placenta in the uterine cavity is due to constriction of theuterine ostium. (Sarwono, Maternal and Neonatal Health Services, 2002: 178).

Bleeding only occurs in the placenta which is partially or completely separated from the uterine wall. The amount or the amount of bleeding depends on the extent of the placenta that has been removed and bleeding can occur. Through checking or pulling on the umbilical cord can be known whether the placenta has been removed or not and if more than 30 minutes then we can do a manual placenta.

Placental retention (*Placental Retention*) is an unborn placenta within half an hour after the fetus is born. While the rest of the placenta (placenta rest) is lagging part of the placenta in the uterine cavity which can cause early postpartum hemorrhage*(EarlyPostpartum*Hemorrhage)or slow postpartum hemorrhage(*LatePostpartum*Hemorrhage),which usually occurs within 6-10 days after the birth.

B. Signs And Symptoms retained placenta

1. placenta accreta Partial / Separation
   a. Consistency uterus chewy
   b. TFU as high as the center \
   c. Forms uterus discoid
   d. Bleeding was - lots of
   e. cord protruding portion
   f. ostium uteri open
   g. separation placenta separated partially
   h. Shock often
2. Placenta incarcerated
   a. Consistency uterus hard
   b. TFU 2 fingers below the center
   c. Form uterus globular
   d. bleeding was
   e. cord protruding
   f. ostium uteri open
   g. separation of the placenta had separated
   h. Shock rarely
   i. Consistency uterus quite
   j. TFU as high as the center
   k. Form uterus discoid
   l. bleeding little / no
   m. cord is not stretched

n. ostium uteri open
o. separation of the placenta attached to the whole
p. shock is rare, except as a result of inversio by a strong pull on umbilical cord. (Prawirohardjo, S.2002: 178

C. Management.

Handling of placental retention or part of the placenta is:

1. Resuscitation. Provision of 100% oxygen. IV-line installation with large diameter catheters and administration of crystalloid fluid (isotonic sodium chloride or ringer lactate solution y) warm, if possible). Monitor heart, pulse, blood pressure and oxygen saturation. Blood transfusion if needed which is confirmed by the results of blood tests.
2. *Drips of oxytocin* (oxytocin drips) 20 IU in 500 mlsolution *Ringer's lactate* or 0.9% NaCl (normal saline) to the uterus to contract.
3. Try placenta birth with *Brandt Andrews*, if successful continue with oxytocin drips to maintain the uterus.
4. If the placenta is not released, try the manual placenta. Manual indications of the placenta are: Bleeding in the third stage of labor approximately 400 cc, retention of the placenta after 30 minutes of childbirth, after difficult artificial labor such as high forceps, extraction versions, perforations, and are needed for exploration of the birth canal, umbilical cord rupture.
5. If manual action of the placenta is not possible, tissue can be removed with pliers (abdominal) abortion followed by curettage of the remaining placenta. In general, removal of the remaining placenta is done by curettage. Curettage must be done in hospital with caution because the uterine wall is relatively thin compared to curettage in abortion.
6. After completion of the removal of the remaining placenta, followed by administration of uterotonic drugs by injection or by mouth.
7. Provision of antibiotics if there are signs of infection and for the prevention of secondary infections. (Sulisetiya.blogspot.com/2010/03).

D. Complications of the

placenta must be excluded because they can be dangerous:

1. Bleeding
   Occurs even more when the retentions of the placenta that have a slight release until the contraction pumps blood but the attached parts make the wound do not close.
2. Infection
   Because as an inanimate object left in the uterus increases bacterial growth is assisted by the port d'entre from the placental attachment site.
3. Incarcerated placenta can occur where the placenta adheres continuously while contracting the ostium well until that occurs.
4. Placental polyps occur as a proliferative mass undergoing secondary infection and necrosis
5. With the inclusion of mutagens, the injuries that were initially physiologic can turn into pathologic (dysplastic-discariotic) and eventually become invasive carcinoma. Once a micro-invasive or invasive, the process of malignancy will continue.
6. This cell looks abnormal but is not malignant. Scientists believe that some of the abnormal changes in these cells are the first step in a series of slow-moving changes, which a few years later can cause cancer. Because of this some abnormal changes are precancerous conditions, which can turn into cancer.

INSTRUCTIONS WORK SKILLS MANUAL

PLACENTAOBJECTIVE OF CONDUCT STUDENT

Mahasiswa can:

1. Prepare tool and ingredients for manual placenta maneuveringplacenta manual
2. Performprocedures and steps correctly

INSTRUCTIONS

1. Prepare materials and tools needed
2. Read and study the work sheet provided by the
3. instructor Follow the instructor's instructions
4. Report the work after completing the work Safety

SAFETY

1. Concentrate attention and concentration the procedure of action
2. Before the procedure, close the tools and materials
3. Use the tool in accordance with its use
4. Ergonomic layout of equipment
5. Use PPE
6. Pay attention to septic and aseptic techniques in performing procedures

EQUIPMENT

1. Bed / table
2. Clean water and soap for washing Hand
3. Towel Small
4. set
5. ParticlesHeacting set
6. Gloves
7. 0.5% Chlorine solution
8. Placenta

MATERIAL

Phantoom Pelvis and Placenta, oxytocin and syringe 3 cc

CHECKLIST & FORMAT PLASENTA MANUAL ASSESSMENT

NO	GRAIN	VALUE		
		0	1	2
A.	**ATTITUDE**			
1.	**Welcome clients with polite and friendly** 1 Not done 2 Giving greetings without looking at the client 3 Giving greetings with looking at the client			
2.	**Introducing yourself to the client** 1 Not done 2 Introducing yourself as a midwife without naming name 3 Introducing yourself as a midwife by naming names while shaking hands / giving a touchto the client kindly			
3.	**Responding to client's reaction** 1 Not responding nonchalantly 2 Responding to client's reaction but not responding appropriately, imperfectly 3 Responding to client's reaction appropriately and politely			
4.	**Confidence** 1 Tested to be nervous, not make eye contact and sound unclear 2 Look in haste and doubt, lack of confidence 3 Look calm and do with confidence			
5.	**Tested giving an empathy for the client** 1 Not done 2 Gives the opportunity to the client to submit a complaint but does not respond properly 3 Give an opportunity to the client to submit a complaint and immediately respondproperly.			
B.	**CONTENT**			
6.	**Positioning the client with lithotomy / dorsal recumbent position** 1 Not done 2 Done perfectly by positioning lithotomy / dorsal recumbent			
7.	**Using PPE (apron, hat, mask, footwear)** 1 Not used 2 Used incompletely 3 Used completely Completelycompletely			
8.	**Washinghands** 1 Not done 2 Do not do with 7 steps 3 Do with 7 steps			
9.	**Use short gloves DTT / Sterile on both hands** 1 Do not use 2 Use without regard to the principle of sterility 3 Use with regard to the principle of sterility			
10.	**Ensure the bladder is empty *** 1 Not done 2 Suprapubic palpation			
11.	**Take off the short right hand glove and wear the long DTT / Sterile glove *** 1 Not done 2 Done with regard to the principle of sterility			
12.	**Left hand tightens the umbilical cord with clamps, parallel to the floor *** 1 Not done 2 Done perfectly			
13.	**Right hand enters the vagina completely obstetric *** 1 No d do the job 2 done perfectly			

14.	**Right hand enters the vagina by tracing the underside of the umbilical cord (back of the hand facing down) *** 1 Not done 2 Done perfectly			
15.	**After reaching the cervix, ask the assistant to tighten the umbilical cord clamps. Then move the left hand to hold the uterine fundus *** 1 Not done 2 Done perfectly (left hand right in the fundus)			
16.	**While holding the uterine fundus, inserting the hand into the uterine cavity until it reaches the placental implantation *** 1 Not done 2 Done perfectly			
17.	**Spread hands obstetrics become flat (thumb close to index finger and other fingersclose together) *** 1 Not done 2 Done perfectly (fingers close together)			
18.	**Determine placental implantation and find parts of the placenta that have been released *** 1 Not doing 2 Done perfectly			
19.	**Inserting the tip finger between the placenta and the uterine wall *** 1 Not done 2 Done perfectly			
20.	**Extending the release of the placenta by sliding the hand to the right and left (with the side of the ulna) while sliding up (cranial mother) until all attachment of the placenta detached from the uterine wall *** 1 Not done 2 Done perfectly (left hand position remains in the fund us)			
21.	**While the right hand is still in the uterine cavity, explore to assess that there is no residual placenta left *** 1 Not donedone 2 Perfectly			
22.	**Move the left hand from the fundus to the supra simphysis (hold the lower uterine segment) *** 1 Not done 2 Done with put the left hand right in the supra simphysis			
23.	**Instruct assistant to pull the umbilical cord while the right hand brings the placenta out (avoid the occurrence of blood splashes) *** 1 Not done 2 Done perfectly			
24.	**Performing uterine pressure towards the cranial dorso (with left hand) *** 1 Not done 2 Done perfectly			
25.	**Placing the placenta in the container provided** 1 Not done 2 Done imperfectPerfect 3 DoneDone			
26.	**Cleaning tools** 1 Not done 2 Done neatly or there is nothing left 3 Done perfectly Done			
27.	**Submerge the tool in 0.5 chlorine solution %** 1 Not done 2 Done imperfectly			

	3 Done do it perfectly			
28.	**Decontaminate aprons with 0.5% chlorine solution** 1 Not done 2 Done imperfectly 3 Done Perfectly			
29.	**Wash gloves then remove them in 0.5% chlorine solution in reverse and soak them** 0 Don't do 1 Done imperfectly 2 Done perfectly			
30.	**Washing hands with soap and running water** 1 Not done 2 Done not with 7 steps2 Done with 7 steps			
31.	**Removing PPE** 0 Not done 1 Done imperfectly 2 Done perfectly			
32.	**Inform the results of the action to the client** 1 Not done 2 Done imperfect 2. Performed perfectly			
C.	**TECHNIQUE**			
33.	**Tested systematically** 1 Not done 2 Performed partially and not sequentiallysequential 3 Performedactions			
34.	**Tested applying infection prevention techniques (PI)** 1 Not done 2 Applying PI techniques is not appropriate 3 Applying PI techniques with Exactly			
35.	**Tested to carry out right communication during action** 0 Not done 1 Carry out communication but in a language that is not easily understood by the client2 Carry out communication using language that is easily understood by the client			
36.	**Maintain client privacy** 1 Not done 2 Maintain privacy by speech or demonstrate closing the door / sampiran 3 Maintain privacy with speech and demonstrate close the door / sampiran			
37.	**Tested to document the results of actions by either** 1 not done 2 documenting action, but did not complete 3 the whole document the results of action with the date, time, name and signature of theimplementing			
	ENTIRE TOTAL SCORE: **74**			

SCORE FINAL= $\frac{\text{Score}\Sigma}{74}$ x 100

MODULE IX. COMPLICATIONS THAT CAN OCCUR IN POST-NATAL

1. Theme Module : Practicum Module Complications that can occur in Post-natal
2. Lectures / Codes : Neonatal Maternity Emergency Nursing Care and BLS / Bd. 5. 026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Allocation of time : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to practice handling complications that can occur in postpartum. Secondary bleeding and PID.
7. Module overview:

   This module will specifically discuss practicum Complications that can occur in complications thatcan occur in post-delivery
8. Characteristics of students:

   This module is intended for semester IV students of D III Midwifery Study Program Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and graduated in achieving Previous subject competency standards are basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, ethicolegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, education education noble character and character, practice of basic skills in midwifery, midwifery and newborn midwifery care, postpartum and breastfeeding midwifery care, neonatal midwifery care, infants, toddlers and preschool children, public health, health promotion, physiological midwifery clinical practice.
9. Competency Targets:

   Students can complete cases Complications that can occur in Post-delivery
10. Indicators:

    Students are able to resolve cases Complications that can occur in Post-delivery
11. Learning material : Attached
12. learning strategies: making resumes of research journal presentations and presentations: Secondary bleeding and PID
13. Learning support facilities: LCD, Computer
14. Procedure (Module Usage Instructions):

    a. For students,

       1) students read and understand the learning objectives, practical assignments to be carried out, read references recommended by
       2) students, discuss discussions about gadar case studies

    b. Role of Teachers / Lecturers

       1) As a facilitator
       2) As a mediator
15. Method of evaluation: debriefing, post test

16. assessment Method: Value score of post-test, the response
17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b .....2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics.* YBPSP.

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SCUNDER BLOODING

Post-partum hemorrhage more than 24 hours after delivery of a

a. Retained Placenta

Placenta or its parts can remain in the uterus after the baby is born.

Causes The

a. placenta has not been released from the uterus walled
b. The placenta has been released but has not yet been born (due to the absence of an attempt togive birth or due to mismanagement of the third)
c. stageUterine contractions are not strong enough to release the placenta.placenta
d. Theis firmly attached to the uterine wall because the chili villi penetrate the decidua to themyometrium until it is below the peritoneum (placenta accreta-percreta)

Management

a. If the placenta is seen in the vagina, ask the mother to push. If you can feel the placenta in thevagina, remove the placenta.
b. Make sure the bladder is empty. If necessary, catheterize the bladder.
c. If the placenta has not come out, give oxytocin 10 IM units, if it hasn't been done in active treatment at stage III
d. If the placenta hasn't been born after 30 minutes of oxytocin and the uterus feels contracted, pull the cord controlled
e. if the cord is controlled unsuccessfully, try to remove the placenta manually. If the bleeding continues, do a simple blood clotting test. Failure to form clots after 7 minutes or the presence of soft clots that can rupture slowly shows coagulation.
f. If there are signs of infection (fever, secretive vaginal odor), give antibiotics for metritis.

b. Birth

canal tear is the second most common cause of postpartum hemorrhage. Tearing can occur simultaneously with uterine atony. Postpartum bleeding with a contracted uterus is usually caused by cervical, or vaginal tears.

Check carefully and repair tears in the cervix, vagina and perineum, do a simple blood clotting test if bleeding continues. Failure to form a freeze after 7 minutes or the presence of a soft clot that can break easily indicates the presence of coagulapati.

Management

a. Improvement of cervical tears
   1) A and antiseptic action on the vagina and cervix
   2) Provide emotional support and explanation
   3) In general, anesthesia is not needed. If the tear is extensive or far up, give petidine anddiazepam IV slowly, or ketamine.
   4) The assistant holds the fundus of the
   5) cervical lip in a pinch with ovum clamps, moving alternately clockwise so that all parts of thecervix can be examined. In the part where there is a tear, leave 2 clamps between the tear.
   6) Sew cervical tears with chromic gut 0 cut completely, starting from the apex.
   7) If it is difficult to reach and tied, musty can be tried in a pinch with ovum clamps or arterialclamps and maintained for 4 hours
   8) If the tear extends to pass through the top of the vagina do laparotomy
b. Repair vaginal tears and perineum

   There are 4 levels of tears that can occur in labor:
   1) Stage I tears that affect the vaginaland connective tissue
   2) mucosaLevel II tears that affect the lower
   3) latency Level III tears about m. sphincter ani
   4) Level IV tears of rectal mucosa

   Repair level IIlevel 1

tears Generallytears can heal on their own, do not need stitches

1) Review basic principles of care
2) Provide emotional support
3) Make sure there is no allergy to lycocaine or similar drugs
4) Check the vagina, perineum and cervix
5) If long and deep tears, check whether the tear is level III or IV:
   a) Put gloved fingers into the anus
   b) Identify sphincter
   c) Feel the tone of the sphincter
   d) Change gloves
   e) If sphincter is affected, see repair of level III or IV tears
   f) If the sphincter is intact, continue repair
   g) A and antisepsis in the tear area
   h) Insert the needle at the tip or corner of the laceration or wound and push it in along thewound following the line where the needle will go in or out.
   i) Aspirate and then inject about 10 ml of 0.5% lignocaine under the vaginal mucosa,under the skin of the perineum, and in the muscles of the perineum.
   j) Wait up to 2 minutes for anesthesia to be effective.

Repair of stage III and IV

tears If rectal tears are not repaired, infection can occur and rectovaginal fistulas

1) Review the basic principles of treatment
2) Perform a pudendal or ketamine block
3) Ask the assistant to hold the fundus and perform a uterine massage
4) Check the vagina, cervix, perineum and rectum
5) Check if the anal sphincter is torn
   - Finger gloved input into the anus
   - Identification of the anal sphincter
   - Check the surface of the rectum
6) Change the glove
7) A / antisepsis in the tear area
8) Make sure there is no allergy to lignocaine or similar drugs
9) Insert the needle at the tip or corner of the laceration or wound and push it in along thewound following the needle line The sewing will go in or out.
10) Aspiration and then inject about 10 ml of 0.5% lignocaine under the vaginal mucosa, underthe skin of the perineum, and on the perineal muscles.
11) Wait 2 minutes for effective anesthesia.
12) Sew the muscles neatly layer by layer with stitches. one-on-one

c. Uterine

inversion In uterine inversion the upper part of the uterus enters k the uterus, so that the inneruterine fundus protrudes into the uterine cavity.

Depth inversio uteri according to the development inversio uteri:

a. Fundus uteri protruding into the uterine cavity, but not yet out of the chamber
b. corpus uteri overturned has entered into vagina
c. uterus with the vagina, everything is upside down, for the most part located outside the vagina

Handling

a. Review the indications
b. Review the basic principles of care and infusion pairs
c. Give petidine and diazepam IV in different syringes slowly, or general anesthesia if needed
d. Wash the uterus with antiseptic solution and cover with a wet cloth (with warm NaCl) beforesurgery

Prevention of inversion

beforemanual correction

a. Put gloves on DTT
b. Hold the uterus in the insertion area of the umbilical cord and enter it back through the cervix. Use the other hand to help hold the uterus from the abdominal wall. If the placenta isstill not released, remove the placenta manually after the corrective action.
c. If the manual correction is unsuccessful, make a hydrostatic correction Hydrostatic Correction The
    a. patient is in the trendelenburg position - with the head lower about 50 cm from the perineum
    b. Prepare a disinfected rinse system, in the form of a 2 m hose with a spraying tip wide hole. The hose is connected with a tube of 3-5 l warm water (or NaCl or other infusion) and attachas high as 2 m.
    c. Identification of the posterior fornix
    d. Attach the end of thehose *douche* to the posterior fornix until it closes the labia around the hose with the hands
    e. Flush water freely to press the uterus into position beginning.

Post-treatment treatment

a. If the inversion has been corrected, give 20 units of oxytocin infusion in 500 ml IV (0.9% NaCl /RL) 10 drops / minute
b. Give a single dose prophylactic antibiotic
c. Perform post-operative care if given a combination of abdominal vaginal correction
d. If there are signs of infection give combined antibiotics until the patient is free of fever for 48hours
e. Give analgesics if necessary.

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OFSTUDENT :
DAY / DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODULE IX. COMPLICATIONS THAT CAN OCCUR IN POST-NATAL

1. Theme Module : Module Practicum Complications that can occur in Post-natal Labor
2. Lectures / Codes : Neonatal Emergency Maternity Care and BLS / Bd. 5. 026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Allocation of time : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to practice handling complications that can occur in postpartum. cases of puerperal infection: infection of the breast
7. Module overview:

   This module will specifically discuss practicum Complications that can occur in Complications thatcan occur in post-delivery
8. Characteristics of students:

   This module is intended for semester IV students of D III III Midwifery Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and passed in achieving the competency standards of previous courses, namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, etholoLegal in midwifery practices, midwifery care of pregnancy, basic obstetric skills, communication communication in midwifery practice, medical science, character education and noble character, practice of basic obstetric skills, midwifery and newborn midwifery care, postpartum and breastfeeding midwifery care, neonatal midwifery care, infants, toddlers and pre-school children, public health, health promotion , pract ik physiological obstetric clinic.
9. Competency Targets:

   Students can complete cases Complications that can occur in postpartum
10. Indicators:

    Students are able to solve cases Complications that can occur in postpartum
11. Learning material : Attached
12. learning strategies: making resumes of research journal presentations and presentations: cases of puerperal infection: breast infections
13. Learning support facilities: LCD, Computer
14. Procedures (Module Usage Instructions):

    a. For students,

    1) students read and understand the learning objectives, practical assignments to be carried out, read references recommended by
    2) students, discuss discussions about gadar case studies

    b. Role of Teachers / Lecturers

    1) As a facilitator

2) As a mediator

15. Method of evaluation: debriefing, post-test
16. assessment Method: Value score of post-test, the response
17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b .....2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis of Obstetrics*. Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics*. YBPSP.

Prepare by	Examined by:	Authorized by:
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BREAST INFECTION IN THE PRINCIPLES (MASTITIS)

A. Definition of Postpartum

The puerperiuminfection is all inflammation caused by the entry of germs into the genital organs at the time of labor and the puerperium. Postpartum fever or puerperal morbidity includes fever in the puerperium for any reason. Puerperal morbidity is an increase in body temperature to 38 ° C or more for 2 days in the first 10 days postpartum, excluding the first day.

B. Breast Infection

1. Mastitis

a. Definition

In the puerperium can occur infection and inflammation in mammals, especially in primipara. Signs of infection are chills accompanied by an increase in temperature, sufferers feel lethargic and no appetite. The cause of infection is staphilococcus aureus. Mamae is enlarged and painful and somewhere, red skin, swelling slightly, and pain on palpation. If there is no treatment, an abscess can occur.

b. Causes

Breast infections are usually caused by bacteria that are found in normal skin (Staphylococcus aureus). Bacteria often originate from the baby's mouth and enter the milkducts through tears or cracks in the skin (usually on the nipples). Mesitis usually occurs in women who breastfeed and most often occur within 1-3 months after giving birth. About 1-3% of breastfeeding women experience mastitis in the first few weeks after giving birth. In postmenopausal women, breast infection is associated with chronic inflammation of the milk ducts located under the nipple. Hormonal changes in the female body cause blockage of milk flow by dead skin cells. These blocked ducts make it easier for breasts to become infected.

1) Swollen breasts that are not breastfed adequately.
2) Bra that is too tight.
3) Nipples of blisters that cause infection.
4) Poor nutrition, insufficient rest and anemia.

c. Symptoms

1) Swelling and pain.
2) The breasts appear red in whole or in certain places.
3) Breasts feel hard and bumpy.
4) There is a fever and general pain.

d. Based on the place of infection can be divided into:

1) Mastitis which causes an abscess under the mammary areola.
2) Mastitis in the middle of the breast causes an abscess in that place.
3) Mastitis in the dorsal tissue under the glands that causes abscesses between mammaryand the underlying muscles.

e. Prevention

Nursing nipple treatment in lactation is an important effort to prevent mastitis. Treatment consists of cleaning the nipple with baby oil before and after breastfeeding to remove crustand dried milk. It also provides assistance to nursing mothers whose babies must be free ofinfection with staphylococus. If there are sores or cracks on the nipples, the baby should not suckle on the breast, and milk can be removed by massage.

f. Treatment

Immediately after mastitis was found the baby's milk was stopped and given the followingtreatment:

1) Give coxacillin 500 mg every 6 hours for 10 days.
2) Breast support
3) Cold compresses
4) If necessary give paracetamol 500 mg orally every 4 hours.

5) Follow the development 3 days after administration.
6) If there is an abscess, the pus needs to be removed with as little incision as possible on the abscess, and the pus is removed after that a pipe is placed in the middle of the abscess, so that the pus can come out. To prevent damage to the lactiferous duct the incision is made parallel to the course of the ducts. Or if there is a solid mass, hardening under reddish skin:
7) Give antibiotic coxacillin 500 mg orally 4 times a day for 10 days or erythromycin 250mg orally 3 times a day for 10 days
8) Drain abscess:
   - General anesthesia is recommended
   - Perform a radial incision from the nipple boundary to lateral to avoid injury or duct
   - Use sterile gloves
   - Loose Tampons with gauze
   - Remove tampons 24 hours replace with small tampons
     a) If there is still a lot of pus keep giving tampons in holes and open the edges
     b) Make sure the mother still uses the cords
     c) Give paracetamol 500 mg if necessary
     d) Evaluation 3 days

g. Handling And The role of the Midwife
1) Breast compressed with warm water.
2) To reduce pain, analgesic treatment can be given.
3) To overcome the infection given antibiotics.
4) The baby starts to suckle from the inflammation of the breast.
5) Encourage the mother to always breastfeed her baby.
6) Encourage mothers to consume nutritious food and get enough rest.
7) supportive counseling
Mastitisis a very painful and frustrating experience, and makes many women feel very sick. In addition to effective treatment and pain control, women need emotional support. Mothers must be reassured about the value of breastfeeding; which is safe tocarry on; that breast milk from the affected breast will not harm the baby; and that herbreasts will recover in both form and function.
8) EffectiveRemoval
BreastBy helping the mother improve the baby's attachment to the breast, encouragefrequent breastfeeding, as often and as long as the baby wants, without restrictions, ifnecessary squeeze breast milk by hand or with a pump or hot bottle, until breastfeeding can begin again.

2. ASI DamBreast milk

a. Definition

dam is a containment of milk due to narrowing of the lactic ducts or by glands that are not emptied completely or because of abnormalities in the nipple (Mochtar, 1996).

According to Huliana (2003) swollen breasts occur due to obstruction of venous blood flow or lymph node channels due to breast milk collected in the breast. This incident arises because of excessive production, while the needs of the baby on the first day of birthare still small.

b. Pathophysiology
1) Symptoms that are common in breast milk dams include full breast feeling hot, heavy and hard, looks shiny, although not reddish.
2) Breast milk usually does not flow smoothly, but there is also an obstructed breast enlarged, swollen and very painful, stretched nipples to be flat.

3) Breast milk does not flow easily and babies find it difficult to suck to suck milk. Motherssometimes get fever, but usually will disappear within 24 hours (Mochtar, 1998).

c. Management and Role of Midwives

Prevention efforts for breastfeeding dams are:

Early breastfeeding, breastfeeding the baby as soon as possible (after 30 minutes) afterbirth

Feed the baby without schedule or ondemandϖ

Give milk by hand or pump, if production exceeds the baby's needsPost-delivery breast care Treatment

efforts for ASI dam is:

1) Compress warm the breasts to make them more soft
2) Take it out a little milk so that the nipple is more easily captured and inhaled by thebaby.
3) After full baby remove the remaining milk
4) for reduce breast pain, give a cold compress
5) to reduce static in the veins and lymph vessels do sequencing (massage) of the breastthat starts from the nipple towards the corpus**.** (Sastrawinata, 2004)

3. BreastBreast

a. Definition

Abscessabscess is different from mastitis. Breast abscesses occur when mastitis is nothandled properly, which aggravates the infection.

b. Symptoms

1) Pain in the breast of the mother looks more severe.
2) Breasts are more shiny and red in color.
3) The lump feels soft because it contains pus.
4) Tense and reddish dense breasts.
5) Swelling in the presence of fluctuations.
6) Pus / pus.

c. Handling and Role of Midwives

1) Proper breastfeeding techniques .
2) Compress the breast with warm and watercold water alternately.
3) Although in a state of mastitis, themust often breastfeed baby.
4) Start breastfeeding in breast a healthy.
5) Stop breast-feeding at the breast an abscess,but breastfeeding should remainexcluded.
6) If the abscess is getting worse and pus is pushing, give antibiotics.
7) Refer if the situation does not improve.

4. Blocked ducts Blocked

ducts can almost always be resolved without specific treatment between 24 and 48 hours after they occur. As long as the blockage is still present, the baby may be fussy when breastfeedingin the breast because the flow of breast milk will be slower than usual. This might be due to pressure from a lump pressing on another channel. Blocked ducts can be treated more quickly if:

a. **Continue breastfeeding on the affected breast, and clear the breast better.** This can be done by: Good

1) **sticking as far as possible** (see the "information sheet*When Lacthing*"and video clip on how to attach baby to the nbci.ca site)
2) **Using pressure on the breast to keep the milk flowing** (see the information attachment "Emphasis" Breast /*Breast Compression*"and video clips on how to attach a baby to the

nbci.ca site). Place your hands around the blocked duct and if it doesn't hurt too much, press while the baby is breastfeeding.

3) **Feed the baby in such a position that the baby's chin "leads" to the blocked duct.** So, ifthere is a blocked duct on the outside of the bottom of the breast (at 7 o'clock), then breastfeeding a baby in *football* can be very helpful.

b. **Warm the infected area.** You can do this with a heating pad or a bottle of hot water, but be careful not to burn the skin by sticking it with too much heat for too long.

c. **Try to get married.** Of course, with the presence of a new baby it is not easy to rest. Try to sleep. Take your baby with you to bed and feed him there.

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OFSTUDENT :
DAY / DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODULE XI. NEONATAL CONDITIONS WITH EMERGENCY EMERGENCY

1. Theme Modules : Practical Module for Neonatal Conditions with Emergency Emergency
2. Subject / Code : Midwifery Emergency Neonatal Maternity CareEmergency
3. Credits : 3 credits (T: 2 credits, P: 1 credits)
4. Time allocation : 2 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain neonatal conditions at risk of emergencies
7. Module overview :

   This module will specifically discuss the practice of neonatal conditions at risk of emergencies byconducting demonstrations and independent practice of resuscitation skills at BBL.
8. Student characteristics :

   This module is intended for fourth semester students of D III Study Program in Midwifery Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and graduated in achieving the competency standards of previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, ethololegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwiferymaternity care and newborns, midwifery and breastfeeding practice, medical science, charactereducation and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, postpartum midwifery and breastfeeding , neonatal midwifery care, infants, toddlers and pre-school children, public health, health promotion, clinical physiological obstetric practice.
9. Competency Targets :

   Students can explain neonatal conditions at risk of emergencies
10. Indicators :

    Students are able to explain neonatal conditions at risk of emergencies
11. Learning material : Attached
12. learning strategies: Discussion, questions and answers, demonstrations and independent practice of resuscitation skills in BBL
13. Learning support facilities: LCD, Computer
14. Procedures Module Usage Instructions):

    a. For

1) Student Students read and understand the learning objectives, practical tasks to be carried out, read references recommended

2) Students practice skills and practices in accordance with the material

Conduct demonstrations and practice independent resuscitation skills at BBL

b. Role of Teachers / Lecturers

1) As a facilitator

2) As a mediator

15. Method of evaluation: debriefing, post test

16. assessment Method: Value score of post-test, the response

17. Bibliography

a. Maryunani Anik. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b .....2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics.* YBPSP.

Prepare by	Examined by:	Authorized by:
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Hesti Kurniasih, S.ST, M.Tr.Keb	Puji Hastuti Ahli (A). M.H.Kes	Dr. Wafin., S.ST., M.Kes
NIP. 199010272023212034	NIP. 19750222 200812 2 001	NIP. 196504231988032002

NEONATAL CONDITIONS WITH EMERGENCY

A. INTRAUTERIN ASFIXIA

1. Definition

Intrauterine asphyxia is a state of oxygen deprivation and the presence of carbon dioxide accumulation which causes intrauterine acidosis due to impaired gas exchange through the placenta.

2. Pathophysiology

Fetal hypoxia that causes neonatal asphyxia occurs due to impaired gas exchange and oxygen transport from mother to fetus so that there is a disruption in the supply of oxygen and in removing carbon dioxide. This disorder can last for years due to conditions or abnormalities inthe mother during pregnancy, or suddenly because of the things suffered by the mother in labor.

Changes in gas exchange and oxygen transport during pregnancy and childbirth will affect the oxygenation of body cells which can further result in impaired cell function. Impaired function can be mild and temporary or persistent, depending on changes in homeostasis found in the fetus. These homeostatic changes are closely related to the severity and duration of anoxia or hypoxia suffered.

At the initial level, interruption of oxygen transport gas exchange may only cause respiratory acidosis. If the disorder continues, anaerobic metabolism occurs in the body. This process is in the form of glycolysis of the body's glycogen, so that the body's sources of glycogen especially in the heart and liver are reduced. Organic acids produced due to metabolism will cause metabolic acidosis. At an advanced level cardiovascular disorders occur due to:

a. Disrupted work of the heart due to the use of glycogen deposits in heart tissue
b. Metabolic acidosis that disrupts the function of heart cells
c. Disruption of blood circulation to the lungs due to the high *pulmonary vascularresistance.*

This acidosis and cardiovascular disorders have a devastating effect on brain cells and can cause death of children or the emergence of advanced symptoms in living children. In general, the changes that occur in asphyxia are:

a. Decreased arterial oxygen pressure
b. Increased carbon dioxide pressure
c. Decreased blood pH
d. Chronic use of glycogen stores for anaerobic metabolism Occurringdeposits
e. changes in cardiovascular system function

3. Classification

a. Acute

Clinicalin the form of episodes of temporary hypoxemia, which is not accompanied by

b. Chronic

Clinicalof hypoxemia in the form of hypoxemia persistent, accompanied by metabolic orrespiratory acidosis.

4. Etiology of

a. utero placental insufficiency
b. Umbilical cord compression

c. Fetal complications eg due to sepsis or bleeding

5. Diagnosis

a. Acute Asphyxia

1) Fetal biophysical profile (such as breathing movements, body movements,fetal flexor tone) reduced or disappeared
2) NSTs and OCTs show abnormalities
3) There are signs of fetal distress

b. asymptomatic Chronic

1) Olophohydramnios
2) PJT
3) Meconium staining in amniotic fluid or fetal outer
4) Doppler sonography: showing inhibited fetal growth.

6. Complications

a. IUGR

Is an obstacle to fetal growth and development in the uterus, so that some fetal parameters are below ten percentiles (less than 2 SD) of the expected gestational age. Thisis due to the state of hypoxia.

b. Acidosis

Hypoxia also causes anerobic metabolism, causing acidosis (decreased pH of fetal blood). Changes in gas exchange and oxygen transport during pregnancy and childbirth will affect the oxygenation of body cells which can further result in impaired cell function. At the initial level this disorder may only cause respiratory acidosis. If the disorder continues, anaerobic metabolism occurs in the body. This process is in the form of glycolysis of the body's glycogen, so that the body's sources of glycogen especially in the heart and liver are reduced. Organic acids produced due to metabolism will cause metabolic acidosis.

c. Intestinal and kidney ischemia, and intraventricular hemorrhage in the brain.

In hypoxia occurs the transfer of blood supply from less important organs (intestine and kidney) to important organs (brain and heart). Thus, hypoxia will cause intestinal and renal ischemia and intraventricular hemorrhage in the brain.

d. Myocardial and cerebral ischemia Severe

hypoxia will cause a decrease in cardiac output resulting in myocardial and cerebral ischaemia. This happens because the work of the heart is disrupted due to the use of glycogen deposits in the heart tissue. Metabolic acidosis that occurs also disrupts the function of heart and lung cells.

e. IUFD A

condition in which there are no signs of fetal life in the womb. Basically, fetal death is the end result of fetal growth disorders, fetal distress and the consequences of infections that are not diagnosed before, so they are not treated.

Acidosis and cardiovascular disorders due to hypoxia have a bad effect on brain cells and can cause death of children or the emergence of advanced symptoms in living children.

f. Stillbirth Stillbirth

is a birth of conception in a state of death that has reached 28 weeks of gestation (or birth weight more or equal to 1000 grams).

Acidosis and cardiovascular disorders due to hypoxia have a bad effect on brain cells and can cause death of a child during pregnancy or during labor.

g. Neonatal Asphyxia

Asphyxia that occurs in newborns is usually a continuation of fetal anoxia / hypoxia.

B. Neonatal Asphyxia

Asphyxia neonatorum is a state of spontaneous and regular respiratory failure shortly after birth. Changes that occur in asphyxia include hypoxia, hypercapnia and metabolic acidosis. In metabolic acidosis, there is a change in aerobic metabolism to anaerobes which will cause more severe blood biochemical abnormalities. This situation will affect the metabolism of cells, tissues and organs, especially vital organs such as the brain, heart, kidneys, lungs that have an impact on impaired function, organ failure until death.

Neonatal asphyxia is a condition where the baby cannot breathe spontaneously and regularly after birth. This is caused by fetal hypoxia in the uterus and hypoxia is related to factors that arise in pregnancy, childbirth or birth soon (Prawiro Hardjo, Sarwono, 1997).

Asphyxia neonatorum is a condition in which a newborn is unable to breathe spontaneously and regularly immediately after birth. This situation is usually accompanied by conditions where hypoxia and hyperapnea and often end in acidosis (Santoso NI, 1992).

Asphyxia neonatorum is a newborn condition that fails to breathe spontaneously and regularly immediately after birth (Hutchinson, 1967). This situation is accompanied by hypoxia, hypercapnia and ends with acidosis. Hypoxia found in asphyxia sufferers is the most important factor that can inhibit the adaptation of newborns to extrauterine life (Gabriel Duc, 1971). Statistical assessments and clinical experience or anatomical pathology show that this condition is a major cause of newborn mortality and morbidity. This was proven by Drage and Berendes (1966) who found that a low Apgar score as a manifestation of severe hypoxia in infants at birth would show a high mortality rate.

Haupt (1971) shows that the frequency of bleeding disorders in infants as a result of hypoxia is very high. Acidosis, cardiovascular disorders and their complications as a direct result of hypoxia are the main causes of failure of adaptation of newborns (James, 1958). This failure will often continue into respiratory distress syndrome in the first days after birth (James, 1959). An anatomical pathology investigation by Larrhoce and Amakawa (1971) showed severe and diffuse necrosis of the brain tissue of infants who died of hypoxia. Therefore it is not surprising that neurological sequelae are often found in people with severe asphyxia. This situation is very inhibiting the physical and mental growth of the baby in the future. To avoid or reduce this possibility, it is necessary to think of specific appropriate and rational actions in accordance with the changes that may occur in asphyxia sufferers.

Asphyxia will get worse if the handling of the baby is not done properly, so that treatment measures are carried out to maintain survival and overcome further symptoms that may arise. To get satisfying results, several factors need to be considered in dealing with babies with asphyxia.

1. Etiology

Each fetus will experience hypoxia relatively soon after birth and the baby will adapt, so the baby cries and breathes. Asphyxia is a continuation of intrauterine maternal and fetal hypoxia caused by many factors.

Maternal factors that can cause neonatal asphyxia, are maternal hypoxia, age less than 20 years or more than 35 years, gravida more than four, low socioeconomic, blood vessel disease that interferes with oxygen exchange and transport, including hypertension, hypotension, disorders uterine contractions and others.

Placental factors can also cause neonatal asphyxia, including thin, small, non-perfect placenta, placental abruption, placenta previa and others. Fetal factors that can cause neonatal asphyxia are premature, Intra-Uterine Growth Retardation (IUGR), multiple pregnancy (gemelli), umbilical cord growing, congenital abnormalities and others. Labor also contributes to the occurrence of asphyxia neonatorum, namely prolonged labor and parturition with action.

The development of a newborn's lungs occurs in the first minutes of birth and then followed by regular breathing. If there is a disruption of gas exchange or oxygen transport from mother to fetus, fetal or neonatal asphyxia will occur. This disorder can arise during pregnancy, childbirth or shortly after birth. Most of the newborn's asphyxia is a continuation of fetal asphyxia, therefore the assessment of the fetus during pregnancy and childbirth plays a very important role for the safety of the baby. Disorders that arise at the end of pregnancy or childbirth are almost always accompanied by anoxia or fetal hypoxia and end in neonatal asphyxia and the baby receives adequate and maximum care at birth.

In general, the following are the factors that cause respiratory failure in infants, including:

a. Maternal factors Maternal

hypoxia can cause fetal hypoxia. This maternal hypoxia can occur due to hypoventilation due to analgesic or anesthetic drugs. Impaired uterine blood flow can reduce blood flow to the uterus which causes reduced oxygen flow to the placenta and fetus. This is often found in the state of uterine contractions, such as hypertoni, hypotension or tetany due to illness or medication, sudden hypotension in the mother due to bleeding, hypertension in eclampsia and others.

b. factors Placental

Gas exchange between mother and fetus is influenced by the extent and condition of the placenta. Fetal asphyxia will occur if there is a sudden disturbance in the placenta, such as placental abruption, placental bleeding and others.

c. Fetal or fetal factors

Compression of the umbilicus will result in disruption of blood flow in the umbilicus blood vessels and inhibit gas exchange between the mother and fetus. Disruption of blood flow can be found in the state of the umbilical cord, the umbilical cord wrapped around the neck, cord compression between the fetus and the birth canal and others.

d. Neonatal factors

Respiratory center depression in newborns can occur due toexcessive use of anesthetic drugs or analgesics in the mother can directly cause fetal respiratory depression, trauma that occurs in labor such as intracranial hemorrhage, congenital abnormalities in infants such as diaphragmatic hernias, atresia or stenosis respiratory tract, pulmonary hypoplasia and others.

2. Pathophysiology

During life in the womb, the fetus's lungs do not play a role in gas exchange because the placenta provides oxygen and lifts CO2 out of the body of the fetus. In this situation the fetal lungs do not contain air, whereas the alveoli fetalcontain fluid produced in the lungs so that the fetal lungs do not function for respiration. Blood circulation in the lungs is currently very low compared to after birth. This is caused by the constriction of arterioles in the fetal lungs. Most of the pulmonary blood circulation will pass through the Ductus Arteriosus (DA)not much into the pulmonary arterioles.

Shortly after birth the baby will take its first breath (crying), at this time the fetal lungs begin to function for respiration. Alveoli will expand and then air will enter and the fluid in the alveoli will leave the alveoli gradually. Along with this the pulmonary arterioles will expand and blood flow into the lungs will increase adequately. Ductus Arteriosus (DA) will begin to closealong with increased oxygen pressure in the bloodstream. Blood from the right heart (fetus)that previously passed through the DA and into the aorta will begin to provide a significant blood flow into the pulmonary arterioles that begin to expand, the Ductus Arteriosus (DA) will remain closed so that the form of extrauterine circulation will be maintained.

Fetal or newborn hypoxia as a result of vasoconstriction and decreased lung perfusion that continues with asphyxia will initially constrict arterioles in the intestines, kidneys, muscles and skin so that the supply of oxygen to vital organs such as the heart and brain will increase. If ascphysia continues, there is a disruption in myocardial function and cardiac output resulting in a decrease in oxygen supply to vital organs and at this time a "Hypoxic Ischemic Enchephalopathy" (HIE) will begin to occur which will cause permanent disruption in the baby until the death of the newborn. "Hypoxic Ischemic Enchephalopathy" (HIE) in newborns willoccur quickly within 1-2 hours if not addressed quickly and appropriately (Aliyah Anna, 1997).

3. Signs and Symptoms

In asphyxia, the next level of change will occur due to several conditions including:

a. Missing sources of glycogen in the heart that will affect heart function.
b. The occurrence of metabolic acidosis which will result in decreased tissue cells including heart muscle causing cardiac weakness.
c. Inadequate alveolar air filling will cause high pulmonary vascular resistance so that blood circulation is disrupted.

Clinical symptoms of infants experiencing a shortage of O2 will occur and rapid breathing in a short period when asphyxia continues, movement will stop breathing, heart rate also decreased, whereas neuromuscular tone barangsur reduced gradually and entered the primary apnue period. Typical symptoms and signs of asphyxia neonatorum include rapid breathing, nasal lobe breathing, cyanosis and rapid pulse.

The following are further symptoms of asphyxia:

a. Respiratory gasping in
b. Heart rate continues to decrease
c. Blood pressure begins to fall
d. Infants appear weak (flaccid)
e. DecreasedOpressure2 anaerobic(PaO2)
f. Increased blood COpressure2 (PaO2)
g. Decreased PH (due to acidosis) respiratoric and metabolic) The

h. use of glycogen sources in children anaerobic metabolism
i. The occurrence of changes in the cardiovascular system
j. Respiratory disturbance
k. is reduced Heart rate
l. Reflexes or weakened baby responseweakened baby's response or
m. Decreased muscle tone decreaseddecreased muscle tone
n. Blue or pale skin color

Diagnosis of neonatal asphyxia can also be established by calculating the APGAR value, paying attention to clinical conditions, the presence of acyanosis, bradycardia and hypotonia. Examination and cardiotocography (KTG) APGAR values 7-10 are categorized as mild asphyxia or normal infants, APGAR grades 4-6 are categorized as moderate asphyxia, APGAR grades 1-3 are categorized as severe asphyxia.

4. Complications

Complications that can occur in asphyxia neonatorum include:

a. Brain edema and cerebral hemorrhage

In asphyxia patients with impaired cardiac function that has continued to cause neonatal shock, so blood flow to the brain will decrease. This situation will cause hypoxia and ischemic brain that results in brain edema, this can also cause brain hemorrhage.

b. Anuria or oliguria

Cardiac ventricular dysfunction can also occur in asphyxia sufferers, a condition known as myocardial dysfunction when it occurs accompanied by changes in circulation. In this situation, more cardiac output will flow to organs such as the mesentrium and kidney. This is what causes hypoxemia in the blood vessels of the mesentrium and kidneys which causes a little urine output.

c. Seizures

In infants were asphyxiated be impaired gas exchange and transport of O2, so patients shortages O2 and COexpenditure trouble2 it can cause seizures in children due to ineffective tissue perfusion.

d. Coma

If severe asphyxia is left untreated, it causes coma because of several things including hypoxemia and bleeding in the brain.

5. Prevention and Treatment

Comprehensive prevention starts from the time of pregnancy in labor and some time afterdelivery. Prevention can be done as follows:

a. Perform inspection routine antenatal least 4 visits
b. Make referrals to health care facilities more complete in pregnancy suspected risk of babies born with asphyxia neonatal
c. Provide corticosteroid therapy antenatal for delivery at gestational age less than 37
d. weeks
e. Monitoring well to fetal well-being and early detection of signs
f. of fetal asphyxia during labor with cardiotocography

g. Improve the skills of obstetric workers in the management of asphyxia neonatorumat
h. each level of health services
i. Increase cooperation of obstetric personnel in monitoring and handling of labor
j. Conducting Essential Neonatal Care consisting of:
    1) Clean delivery and safe
    2) Temperature stabilization
    3) Initiation of spontaneous breathing
    4) Early breastfeeding initiation
    5) Prevention of infection as well as immunization

Special management of asphyxia neonatorum babies is by immediate resuscitation measures. era after birth. Resuscitation immediately after birth is an attempt to open the airway, making sure that oxygen enters the baby's body by blowing the breath into the baby's mouth (respiratory resuscitation), moving the heart (cardiac resuscitation) until the baby is able to breathe spontaneously and the heart beats regularly.

Resuscitation is carried out in accordance with the stage of resuscitation and is highly dependent on the degree of asphyxia (mild, moderate and severe), a state of breathing with impaired cardiac function, a state of breathing with a non-throbbing heart condition, and the presence or absence of aspiration meconium. In severe asphyxia, an endotracheal tube is required. Sodium Bicarbonate is only given in conditions of metabolic acidosis and is given with caution, because this fluid is hypertonic which facilitates intracranial hemorrhage.

In addition to resuscitation, infants with neonatal asphyxia also need supportive therapy and medical therapy. Supportive therapy is given in the form of 5-10% dextrose infusion fluid to prevent hypoglycemia, electrolyte fluid to meet the needs of electrolytes and the provision of adequate oxygen. Medical treatment is intended to prevent cerebral edema by corticosteroids (still controversial) and phenobarbital to localize bleeding and reduce cerebral metabolism.
In essence, the management of asphyxia in newborns with newborn resuscitation measures follows the stages known as ABC (Airway, Breath, Circulation) resuscitation, namely:

a. Ensuring open channels
    1) Put the baby in a deflection head position and shoulders propped 2-3 cm
    2) Sucking the mouth, nose and sometimes the trachea
    3) If necessary insert an endo trachel pipe (ET pipe) to ensure that the respiratory tract is open
b. Starting breathing
    1) Use tactile stimulation to start breathingto tactile)
    2) Use VTP if necessary such as: lid and balloon endotracheal tube and balloon or mouth to mouth (avoid exposureinfection)
c. Maintaining circulation
    1) Stimulation and maintaining blood circulation
    2) Chest Compression
    3) Treatment

INSTRUCTIONS RESUSITATION FOR NEW BORN BABY SKILLS

OBJECTIVE STUDENT BEHAVIOR

Students can:

1. Prepare tools and materials for BBL resuscitation maneuvers
2. Implement procedures and steps for BBL resuscitation correctlyBBL resuscitation.

INSTRUCTIONS

1. Prepare materials and tools required
2. Read and learn the work sheet / job sheet that has been provided
3. Follow the instructor's instructions for
4. Report the work after completing the exercise

SAFETY WORK

1. Focus attention and concentration on the procedure of action
2. Before the procedure, bring the tools and materials together
3. Use the tool according to its use
4. Ergonomically positioned equipment
5. Use APD
6. Pay attention to septic and aseptic techniques in carrying out procedures

EQUIPMENT AND MATERIALS

1. Bed / table
2. Water clean and soap for hand washing
3. Small towels
4. Partus set
5. Heacting set
6. Gloves Gloves
7. Chlorine solution 0.5%
8. Placenta place
9. Phantoom Resuscitation RESLITATIONRESUSITATION

RESUSITATION NEW BORN BABY

NO	GRAINS	VALUE		
		0	1	2
A.	**ATTITUDE**			
1.	**Greet politely and kindly and position the patient** 1 Not acted an 2 Greets withoutpatient positioning 3 Greetsand positioning the patient			
2.	**Introduce yourself to the patient's family** 1 do not 2 introduce ourselves as a midwife without naming 3 Introducing himself as a midwife by name while shaking hands			
3.	**Responding to the reaction of patients** 1 not responding to 2 the patient's response to the reaction but not responded appropriately 3 Responds to the patient's reaction appropriately			
4.	**Confidence** 1 Tested nervous, did not make eye contact and voice less clear 2 Looked in a hurry and hesitated 3 Look calm and do it with confidence			
5.	**Tested giving empathy to patients** 1 Not done 2 Give a chance to patients to submit complaints but do not respond properly 3 Provide opportunities for patients to submit complaints and immediately respond properly.			
B.	**CONTENT**			
6.	**Using PPE** 1. Not done 2. Done imperfectly 3. Done Perfectly			
7.	**Wash hands** 1. Not done 2. Done imperfectly 3. Done Perfectly			
8.	**Explain indications of resuscitation actions namely: baby is not breathing / gasping for breath, bad muscle tone and gestational period less *** 0 Don't mention or mention incomplete2 Do it perfectly			

9.	**Wear short gloves on both hands** 1. Not done Not done 2. Perfectly 3. done Perfectly			
10.	**Initial steps:** **Keeping the baby warm: replacing the baby blanket with a dry blanket, baby wrapped so that warm, except for the baby's face, then move the baby to the resuscitation table /action table *** 0 Not done or done imperfectlyperfectly			
11.	**Positioning the baby: lay the baby on his back with his head near the helper, prop your shoulders so that the head is slightly extended and make sure the airway is open *** 0 Do not do or do not k perfect2 Done perfectly*a*			
12.	**Clean the airway by sucking mouth and nose not too deep in the throat with dee lee. Suck the lender from the mouth first then the nose, mouth no more than 5 cm, nose no more than 3 cm *** 0 Not done or done imperfectlyperfectly			
13.	**Drying the whole body of the baby with the position tilted to one side, one hand the helper holding the baby's armpits on the other hand dries by applying a little pressure and applying tactile stimulation gently (rubbing the baby's back gently) *** 0 Not done or done imperfectlyperfectly			
14.	**Changing wet cloth with dry cloth** 1. Not done 2. Done imperfectly 3. Done Perfectly			
15.	**Rearranging baby's head and covering the baby *** 0 Not done or doing imperfectly2 Done perfectly			
16.	**Reassessing baby's condition *** 1. Not done 2. Assessing baby's condition			
17.	**Conducting ventilation: Putting a lid on the face baby, cover mouth, nose and chin *** 1. Not done 2. Put on closure on baby's face, covering mouth, nose and chin			
18.	**Gluing lid attachment to face *** 1. Do not close the lidproperly 2. gluingRetaining cap attachment properly			

19.	**Check the attachment of lid with 2 x ventilation and observe the development of the chest *** 1. do not do 2. perfectly			
20.	**perform ventilation with 20 x hoot within 30 seconds, while observing the development of the chest and stopped to assess airway using a stethoscope *** 1. do not perform 2. perform perfectly			
21.	**Picking up tools and soaking them in 0.5% chlorine solution** 1. not do 2. Conducting but not perfect 3. Doing perfectly			
22.	**Removing gloves, previously washed in lart chlorine, taking off in reverse** 1. Do not do 2. but not perfect 3. Do perfectly			
23.	**Wash hands** 1. Do not do 2. but not perfect 3. Do perfect			
24.	**Tell the results of the action to parents** 1. Do not do 2. Do but not perfect 3. Me do it perfectly			
C.	**TECHNIQUE**			
25.	**Tested systematically** 1 Performed partially and non-sequentialsequentialactions 2 Performedactions			
26.	**Tested to apply infection** 1 prevention techniques Applying infection prevention techniques incorrectly2 Applying infection prevention techniques appropriately			
27.	**Maintaining patient privacy** 1 Not done 2 Maintaining privacy only by saying **or**demonstrating closing the door / sampiran 3 Maintaining privacy by saying **and** demonstrating closing the door / sampiran			
28.	**Tested carrying out communication during action** 1 Not carried 2 out Conducting communication but by using language that is not easily understood bypatients 3 Implementing communication using easy language understood by patients			

29.	**Tested documenting the results of actions well** 1 Not done 2 Documenting the results of actions without the identity of the executor 3 Documenting all results of the action with the date, time, name and signature of theimplementer			
	TOTAL SCORE ENTIRE: **5 8**			

END VALUE = Σ Score x 100

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MODUL XII. PRACTICUM MODULE COMPLICATIONS THAT CAN OCCUR IN NEWBORNS AND INFANTS

1. Module Theme : Practicum Module Complications that can occur in newborns and Infants
2. Subject / Code : Emergency Neonatal Maternity and BLS / Bd.5.026
3. Total Credit : 3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain Complications that can occur in newborns and infants, toddlers
7. Overview of the module:

   This module will specifically discuss the practicum Complications that can occur in newborns and infants, toddlers by conducting demonstrations and independent practice resuscitation skills at BBL (continued)
8. Characteristics of students:

   This module is intended for semester IV students of Study Program D III Midwifery Purwokerto Poltekkes Ministry of Health Semarang who have participated in learning and passed in achieving competency standards previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, concept of midwifery, religion, citizenship, ethicolegal in midwifery practice, maternity midwifery care, basic midwifery skills, communication in midwifery practice, medical science, character education and noble character, practice of basic obstetric skills, midwifery care and newborn, midwifery care, medical science, character education and noble character, practice of basic skills of midwifery, midwifery care and newborn, midwifery care, medical science, character education and noble character, practice of basic skills of midwifery, midwifery care and newborn, midwifery childbirth and breastfeeding, neonatal midwifery care, infants, toddlers and preschoolers, public health, health promotion, clinical physiological obstetricpractice.
9. Competency Targets:

   Students can explain Complications that can occur in newborns and infants, toddlers
10. Indicators:

    Students are able to explain Complications that can occur in newborns and infants, toddlers
11. Learning material : Attached
12. learning strategies: Discussion, questions and answers, demonstrations and practices Mandiri resuscitation skills at BBL (continued)
13. Supporting learning facilities: LCD, Computer
14. Procedures (Instructions for Module Use):

    a. For Students

    1) Students read and understand the learning objectives, practical assignments to be carried out, reading references recommended
    2) Students practice skills and practices in accordance with the material The

lecturer conducts a demonstration and students practice independent resuscitation skills on BBL(continued)

b. The Role of Educators / Lecturers

15. Evaluation methods: questions and answers, post-test
16. Assessment methods: Post-test score scores, response to
17. Bibliography

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COMPLICATIONS THAT CAN OCCUR IN NEWBORNS AND INFANTS

A. NEW BORN BABY WITH HYPOGLICEMIAGlucose

- Regulation of human fuel
- Sources of energy storage in the form of glycogen, fat and protein
- Rapid energy source
- Important for cerebral energy metabolism

Research

- Baby's brain can use glucose at speeds exceeding 4-5 mg / 100 gr by weight brain / minute
- Neonatal brain weighs 420 grams, in BB babies 3500 grams requires glucose with a speed of 20 mg / minute The
- brain grows fast in the first year because the proportion of glucose changes is greater used for brain metabolism, hypoglycemia can be repeated

Hypoglycemia in neonates

- for any neonate, glucose level <40-45mg / dL is considered abnormal
- According to WHO hypoglycemia is when glucose / blood sugar levels <47 mg / dL
- Symptoms are often unclear / asymptomatic, all health professionals need to be aware of the possibility of hypoglycemia
- Early diagnosis and treatment that is can appropriately prevent serious consequences

Causes and mechanisms hypoglycemia Decreased supply and decreased glucose productionNeonates who are at risk for this condition:

- Fetus that has stunted fetal growth (PJT) or a small period of pregnancy
- Premature or even later babies
- Neonates who have delayed intake of
- Neonates who suffer from perinatal asphyxia
- Neonates with hypothermia and or stress

coldIncreased glucose utilization (hyperinsulinism) neonates at risk for this condition:

- IDM-BMK (large gestation)
- neonates with polycythemia
- neonates suffering from hemolytic disease of the newborn (Rh isoimmunization-weight)
- neonates with syndrome Beckwith-Wiedemann
- Neonates with nesidioblastosis or adenoma pankretik
- Malposition catheter UA

Both of these mechanisms, Other

- Adrenal Insufficiency
- Sepsis
- Glycogen storage
- Exchange transfusion
- diseaseCongenital heart disease
- Medication for mothers (steroids, beta blockers)

Incidence of

- 2-3 / 1000 live births
- Incidence increases in:
  - Prematurity, this is not related to storage of liver glycogen, low muscle protein, inadequate acidity,hypothermia, asphyxia and inadequate body fat.
  - Mother DM (75%)

Limitation

- arises when the serum glucose level is lower than the range of normal babies according to post-birthage
- Babies atterm BB 2500 gr : blood sugar <30 mg / dl: 72 hours, then 40mg / dl

- LBW: GD <25 mg / dl

Risk factors for

- infants from mothers with diabetes mellitus (IDM)
- Large neonates for gestational masses (BMK)
- Premature babies and more months
- LBW the KMK / twins can decrease liver and body fat glycogen reserves
- Infants are seriously ill due to increased metabolic requirements that exceed the calorie reserves
- of sick or stressed neonates (respiratory distress syndrome, hypothermia)
- Babies with genetic disorders / metabolic disorders (glycogen reserve diseases, intolerance glucose)
- Fasting
- neonate Neonate with polycythemia
- Neonates with erythroblastosis
- Maternal drugs such as steroids, beta sympathomimetics and beta blockers

Diagnosis

- to prevent o neurodevelopmental abnormalities, timely identification and treatment for hypoglycemia isvery important.
- Monitoring glucose in bed is the right course for screening and early detection.
- Hypoglycemia must be confirmed by serum values from the laboratory if possible

Anamnesis

- Infant history Asphyxia, hypothermia, hypertension, respiratory disorders, premature
- Infant history with mother DM

Clinical manifestations

Cases can show symptoms or not. High suspicion should always be applied and always anticipate hypoglycemia in neonates with risk factors

- Tremor
- Cyanosis
- Apathy
- Seizures
- Intermittent ApneaApnea IntermittentApnea Intermittent
- Weak / squeaky cryWeak / squeaky crymonitoring Weak / squeaky
- LetargiLetargi
- Difficulty in drinkingDifficulty in drinkingDifficulty drinking
- Rotating eye movements / nystagmusRotating eye movements / nystagmus
- Cold sweatCold sweat
- PalePale
- HypothermiaHypothermia
- Less suction reflexesLess suction reflex
- VomitingVomiting

ManagementManagement

Monitorhigh blood pressurescreening:

- At birth
- 30 minutes after birth
- Then every 2-4 hours for 48 hours or until drinking is running well andlevelsnormal glucoseare reached

Prevention of hypoglycemia

- Avoiding preventable risk factors, for example hypothermia
- Enteral feeding is the single most important preventive measure
- if baby is not possible to breastfeed, start drinking by using sonde within 1-3 hours after birth
- High-risk neonates should be monitored for glucose values until the intake is full and 3xnormal measurements before drinking are above 45 mg / dL
- If this is difficult al, intravenous therapy with 10% glucose should be started and glucose levelsmonitored

Hypoglycemia treatment

- Immediate correction with bolus 200 mg / kg with dextrose 10% = 2 cc / kg and given intravenouslyfor 5 minutes and repeated as needed
- Continuous infusion (continuous) 10% glucose at a rate of 6-8 mg / kg / min must be started The
- glucose infusion rate (GIR) is calculated according to the following

formula:GIR (mg / kg / min) = liquid velocity (cc / hour) x dextrose concentration (%)
6x weight (Kg)

- Frequent monitoring of glucose in bed (bed side) is needed to ensure that neonates get adequate glucose.
- When feeding is tolerated and the value of glucose monitoring in the bed (bed side) is normal, the infusion can be gradually reduced. This action may take 24-48 hours or more to avoid the recurrence of

hypoglycemia Refractory hypoglycemia

- Glucose requirement> 12 mg / kg / min indicates hyperinsulinism. This condition can becorrected with
- Hydrocortisone 5 mg / kg IV or IM every 12 hours
- Glucagon 200 ug IV (immediate or continuous infusion of 10 ug / kg / hour)
- Diazoxide 10 mg / kg / day every 8 hours inhibits pancreatic insulin secretion

Therapy

- without seizures, intravenous bolus 200 mg / BW (2 ml / kgBB) 10% glucose
- There are seizures, 10-25% glucose solution, total dose 1-2 gr / kgBB, followed byglucose infusion of 4-8 mg / kgBB / minute
- Repeated hypoglycemia, glucose infusion 15-20%, if inadequate give hydrocortisone 2.5 mg / kgBB / 12 hours or prednisone 1 mg / kgBB / 24 hours
- Check blood sugar to levels above 40 mg / dl then the examination is continued every 4-6hours
- If blood sugar is normaldiscontinued therapy
- Breastfeed
- Handlingcomplications

Prognosis

- When no congenital abnormalities
- With adequate treatment of hypoglycemia was repeated in 10-15% of
- severe and prolonged hypoglycemia, can cause neurologic sequelae and death of

B. NEWBORN WITH SEPSIS

DefinitionSepsis Sepsis Neonatorum and Prevention Neonatal sepsis is an infection of the bloodstream all infants during the first 28 days following birth. This infection can spread thoroughly or be located in only one (1) organ, such as the lungs with pneumonia. Infection in sepsis can occur or be obtained just before delivery (intrauterine sepsis) or after delivery (extrauterine sepsis) and can be caused by viruses (rubella, herpes), bacteria (streptococcus B), and fungi or fungi (candida), although rarely found. (John Mersch, MD, FAAP, 2009).

Neonatal sepsis is a severe infection in neonates with systemic symptoms and bacteria in the blood. The course of sepsis can take place so quickly that it is often not monitored without adequate treatment, sothat neonates can die within 24 to 48 days. (Surasmi, 2003).

Neonatal sepsis is also an infection that occurs in infants within the first 28 days after the baby's birth. (Mochtar, 2005).

Etiology

The cause of neonatal sepsis or neonatal sepsis is due to various kinds of germs such as bacteria, viruses, parasites, and fungi.

The risk of developing sepsis is premature rupture of membranes and bleeding or infection in the mother.

Premature babies who undergo intensive care will be susceptible to sepsis because their immune

systems are not yet developed and they usually undergo invasive procedures such as catheter placement, long-term infusion, and breathing through a tube connected to a ventilator. Organisms that normally live onthe surface of the skin can enter the body and then into the bloodstream through tools such as those mentioned above.

C. A NEW BABY BORN WITHSEIZURE

1. ADefinition

A seizure is a disorder of the central nervous system that occurs suddenly with clinical manifestations of loss of neuromotor coordination.

Seizures in newborns are seizures that occur in the neonatal period or within 38 days after birth. This seizure is an important sign of other diseases as a cause of seizures, which can cause sequelae that persist later in life. If the cause is known, this disease must be treated immediately. Nenonatus seizures are not the same as seizures in children or adults because clonic convulsions tend not to occur during the age of the first month. The healing process of axons and dendritic protrusions is also incomplete myelination in the neonatal brain.

2. The etiology of

- Perinatal Complications
- metabolic disorders
- Infection

3. SeizuresClassification

a. Subtle

Represents common seizure types that occur in preterm infants. This form of seizure is almost invisible, usually in the form of facial movements, mouth, or tongue in the form of grinning, jerking, sucking, shaking, swallowing, or yawning. The manifestations of subtle seizures in the eye are flickering eyeball movement, horizontal eyeball deviation and fast eyeball movement (nystagmus jerk). In the limbs we get pedaling or like swimming. Manifestations in breathing are usually in theform of apnea.

b. Clonic

The clinical form of clonic seizures lasts 1-3 seconds, not accompanied by disturbance of consciousness. This form of seizure results in focal trauma to the cerebral contusions in large infants or term infants, or in metabolic encephalopathy disorders.

c. Tonic Tonic

seizures are commonly found in low birth weight infants with a gestational period of less than 34 weeks and infants with severe perinatal complications such as intraventricular hemorrhage. The clinical form of this seizure is leg movement that resembles the attitude of deseberation or leg extension and flexion of the forearm with a form of decortication.

d. Myoclonic

Clinical manifestations of visible myoclonic seizures are the extension or flexion of the arms or all four limbs which are repetitive and occur quickly. The movement is like a Moro reflex. This seizure is a sign of extensive and severe central nervous system damage, as in newborns born to drug addicted mothers.

Assessment of Diagnosis of

4. Anti-seizure Drug

a. Diazepam

- Dosage 0.1-0.3 mg / kg IV, injected slowly until the seizure stops. It can be repeated in repeated seizures, but it is not recommended for use at maintenance doses.

b. Phenobarbital

- Dosage 5-10 mg / kg IV is injected slowly for several minutes. If the seizure continues, phenobarbital can be repeated with a maximum dose of 20 mg / kg. The maintenance dose is 5-8 mg / kg / day divided into 2 doses.

c. Phenytoin (Dilantin)

- Dosage 5-10 mg / kg IV is injected in 5-10 minutes. Can be repeated again 5-10 minutes. Phenytoin is given if seizures cannot be overcome with a dose of Pharobarbital 10-20 mg / kg. It is recommended that Phenytoin be given 10-15 mg / kg IV on the first day, followed by a maintenance dose of 4-7 mg / kg IV or oral in 2 doses of

Seizure Management in Newborns

Signs	Tremor, hyperactivity, convulsions, sudden arrived shrill crying, muscle tone islost accompanied or not with a loss of awareness of involuntary movements (involuntary movements), nystagmus or paroxiksmal eye blinking.	
CATEGORIES	Tetanus neonaturumSepsis Initiating Ensepality	* Metabolic disorders (hypoglycemic o rhypocalcemic). • Anoxia of the central nervous system. Brain hemorrhage.
ASSESSMENT		
Form of seizure Duration of seizure Body temperature Awareness Signs of other infections	• Whole body / local • Instant or <1 minute • With heat • awareness • Decreased Sluggish / drowsy /do not want to drink	• Entire body / local • Instant or <1 minute • No heat • Conscious • Normal, want to drink
HANDLING		
Midwife or Puskesmas	• Clean the airway • Put a spoon / sepatel in a cloth wrap to press the tongue • Give oxygen • Overcome seizures with Diazepam 0.5 mg / kg suppository / im every 2minutes until the spasm is resolved. • Given phenobarbital 30 mg im • Dextrose infusion of 10% (see the table of basic fluid and calorie requirements in neonates) • Given antibiotics 1 dose (clay table types and antibiotic doses). • Refer the hospital.	
HOSPITAL	• Same as above • Infants in indicator / warmed • Give oxygen • Give Diazepam 0.5 mg / kg suppository / im / iv • Then given phenobarbital 30 mg iv / im • If still seizures given phenytoin 15 mg / kg iv followed by 2 mg / kg every12 hours. • Dektrose infusion of 10% 6o cc / kg • Give calcium gluconate 2 ml / kg within 5-10 minutes.	

FORMAT ASSESSMENT PRESENTATION / SEMINAR

COURSE :
GROUP :
NAME OFSTUDENT :
DAY / DATE :
SUBJECT :

THE MATERIALS ARE CONSIDERED	WEIGHT	VALUE	DESCRIPTION
Attitude Value	30%		NA = 1+2+3 / 3
3/3 Member greetings			NA =
Teamwork			
Readiness organizes audience			
Preparation and Implementation	50%		NB = 1+2+3+4+5+6 / 6
6/6 Material readiness, Facility readiness and infrastructure, and claritypresenting material			NB =
Ability to emphasize important matters			
Ability to master material			
Ability to use facilities and infrastructure			
Ability of group cooperation2/2			
Timeliness			
Evaluation	20%		NC = 1+2 / 2
Ability to conclude			NC =
Ability to close presentation			

Final Value = (NA x 30%) + (NB x 50%) + (NC x 20%)
Final Value =
Note: The range of values is 0 - 100

Purwokerto, …… ....

(…… ..)

MODUL XIII. EARLY HANDLING AND EARLY DETECTION OF MATERNAL AND NEONATAL EMERGENCY CASES

1. Module Modules : Practicum Module for early handling and early detection of maternaland neonatal emergency cases
2. Subject / Code : Neonatal Maternal Emergency and BLS / Bd. 5. 026
3. Total Credit :3 Credit (T: 2 Credit, P: 1 Credit)
4. Time allocation : 1 x 170 minutes
5. Semester IV
6. Learning Objectives: Students are able to explain the basic concepts of neonatal maternal emergencies
7. overview:

   ModuleThis module will specifically discuss about practicum basic concepts of neonatal maternalemergency by conducting initial handling of maternal and neonatal emergency cases.
8. Student characteristics:

   This module is intended for fourth semester students of D III Study Program in Midwifery Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and graduated in achieving the competency standards of previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, ethicolegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery maternity care and newborn, postpartum midwifery and breastfeeding practice, medical education, character education and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, midwifery and nursing midwifery , neonatal midwifery care, infants, toddlers and pre-school children, public health, health promotion, clinical physiological obstetric practice.
9. Competency Targets: Students can explain the basic concepts of neonatal maternal emergencies
10. Indicators: Students are able to explain the basic concepts of neonatal maternal emergencies
11. Learning material : Attached
12. learning strategies: Discussion, questions and answers, PBL
13. Learning support facilities: LCD, Computer
14. Procedures (Module Usage Guide):

    a. For

    1) Student Students read and understand the learning objectives, practical assignments to be carried out, read references recommended
    2) Students practice skills and practices in accordance with the material

    b. The Role of Educators / Lecturers
15. Evaluation methods: questions and answers, post-test
16. Assessment methods: Post-test score scores, response to

17. Bibliography

a. Anik Maryunani. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b ..... 2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics.* YBPS

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EARLY HANDLING AND EARLY DETECTION OF MATERNAL AND NEONATAL

A. Basic Concepts of Maternal Emergency

1. Definition, Purpose, Scope The
   a. definition of

      emergency can be defined as a serious and sometimes dangerous situation that occurs suddenly and unexpectedly and requires immediate action to save lives / lives.

      Maternal emergencies are life-threatening health conditions that occur in pregnancy or during and after labor and birth. There are many diseases and disorders in pregnancy that threaten the safety of mother and baby.

      Maternal emergency cases are obstetric cases which if not treated immediately will result in the death of the mother and fetus. This case is a leading cause of death of fetal mothers and newborns.

   b. Objective:
      1) To prevent death and disability (to save life and limb) in mothers with emergency situations.
      2) Referring mothers with emergencies through a referral system to obtain more adequate treatment.

   c. Scope
2. The scope during pregnancy

   Emergency can occur during the process of pregnancy, including:

   a. Abortion: the threat or release of the results of conception before the fetus can live outside the womb with a gestational age limit <20 mgg or bb <500 grams cause: growth abnormalities resulting from conception, abnormalities in the placenta, chronic maternal disease, nutritional factors, psychological factors
   b. Placental abruption: removal of part / all of the maternal surface of the placenta from the site of the implant. Cause: the primary cause is not yet known with certainty, but there are certain circumstances, the eco-social category, physical category, abnormalities in the uterus, maternal diseases.
   c. Placenta Previa: Placenta that implants in the lower uterine segment in such a way that it covers all / part of the internal uterine ostium so that the placenta is in front of the birth canal.

   Pre eclampsia and Eclampsia

   a. Mild preeclampsia is hypertension accompanied by proteinuria / edema after 20 weeks UK intropolas.
   b. Severe preeclampsia is a pregnancy complication which is marked by the onset of hypertension 160/100 mmHg / more accompanied by proteinuria / edema in the UK 20 weeks / more.
   c. Eclampsia is an acute abnormality in pregnant women, in labor / childbirth which is characterizedby the emergence of seizures that previously have caused symptoms of pre-eclampsia.
3. Emergency emergency in
   a. shoulder dystocia

      Failure to spontaneously give birth to a shoulder. Causes: pelvic deformias and shoulder failure to fold into the pelvis 2.

   b. PP

      Bleeding Bleeding exceeds 500 ml that occurs after the baby is born.

   c. Uterine Atonia

      Occurs when the myometrium does not contract. Causes: polyhydramnios, twin pregnancies, macrosomia, prolonged labor, labor too fast, labor with oxytocin induction / acceleration, intrapartum infection, high parity.

   d. Injury to the birth canal

      Bleeding in a condition where the placenta has been born completely and uterine contractions are good. consists of: perineal tears, vulvar hematomas, vaginal wall tears, cervical tears, uterine ruptures Unborn

      placenta within half an hour after the fetus is born. Causes: adhesival placenta, accreta, incarceration.

B. Basic Concepts of Neonatal Emergency

1. Definition, Purpose, Scope The
   a. definition of

      Emergency Emergency is to include diagnosis and action on all patients who requiretreatment that is unplanned and abrupt Placenta or to patients with acute illness or injury to reduce

morbidity and mortality.

Neonates are organisms that are in in the period of adaptation of intrauterine life to extrauterine. The neonates period is a period of one month (more precisely 4 weeks or 28 days after the baby is born).

Neonatal emergencies include the diagnosis and action of organisms that are in the period of intrauterine life adaptation to extrauterine that requires unplanned and sudden care, and to reducethe morbidity and mortality rate of patients.

b. Objective

To find out the emergencies of neonates

To determine the conditions that cause emergencies in emergencies. neonatesto determine the handling of emergency in neonatal

c. scope

the scope of emergency neonatal namely:

2. LBW

Definition: BB births less than 2500 grams regardless of gestation

Cause: Delivery preterm / premature and infants born small for gestational age

3. Asphyxia in newborn

Definition : Failure to breath spontaneously and regularly at birth / few moments after birth

Cause: in connection with the mother's condition, a problem with the umbilical cord andplacenta, and problems in the baby during / after delivery

4. infant Seizures in Ba ru Birth

Sudden changes in neurological function both motoric and autonomic functions due to excess electrical emission in the brain

C. General Principles for Management of Maternal Emergency

- Ensure free airway
- Oxygen
- administration of intravenous fluids
- Provision of blood transfusions Provision of
- bladder catheters
- Provision of antibiotics
- Pain reduction drugs
- Handling problems Problems handling Main
- Reference

D. Principle of Neonatal Maternal Emergency Management

1. Basic principles, initial assessment, initial clinical assessment

a) Basic principles

1) Respect patient rights

Every patient must be treated with respect, regardless of social and economic status. In this case officers must understand and be sensitive that in emergency situations and conditions feelings of anxiety, fear, and concern are natural for every human being and family who experience them.

2) Gentlenes

In conducting examinations or providing treatment each step must be carried out with full tenderness, including explaining to patients that pain or discomfort can not be avoided when examining or providing treatment, but the procedure will be carried out as gently as possible so that the discomfort is attempted as little as possible

3) Communicative

Health workers must communicate with patients in appropriate language and sentences, easy to understand, and pay attention to norm values local culture. In conducting the examination, the health worker must explain to the patient what will be examined and what is expected. If the examination results are normal or the patient's condition is stable, efforts to ensure that must be done. Explaining the real condition to patients is very important.

b) Patient's

rights Patient's rights must be respected such as the explanation of informed consent, the patient's right to refuse the treatment to be given and the confidentiality of the patient's medical status.

c) Family Support Family support

for the patient is very much needed. Therefore, health workers must strive to do so, among others, by always providing an explanation to the patient's family about the patient's condition, sensitive to family problems related to financial limitations, limited transportation, and so on.

d) Initial assessment The initial

assessment is a step to quickly determine which obstetric cases are suspected of being in an emergency situation and need immediate help by identifying the complications encountered. In this initial assessment, a full history has not been made. The initial history is carried out jointly check the views, touch, and assess vital signs and only to obtain information that is very important related to the case of

e) the Early Clinical Assessment The

examination carried out for initial assessment is as follows:

1. Assessment by examining the view
   Assessing the patient's consciousness
   Assessing the patient's face Assessing
   Respiration
   Assessing bleeding from the genitals
2. Assessment by checking palpation
   Skin, pulses, legs / lower limbs
3. Assessment of vital signs
   Blood pressure, pulse, temperature and breathing

WORK INSTRUCTIONS STABILIZATION SKILLS OFPEB PATIENTS

OBJECTIVESTUDENT BEHAVIOR

Students can:Students

1. Prepare tools and materials for PEB patient stabilization
2. measures Implement procedures and steps for patient stabilization of PEB correctly

INSTRUCTIONS

1. Prepare materials and tools needed
2. read and study the work sheet / job sheet that has been provided
3. Follow the instructor's instructions
4. Report the work after completing the work

SAFETY

1. Concentrate on the concentration of the procedure procedures
2. Before the procedure, close the tools and materials
3. Use the tools according to their use
4. SafetyErgonomic equipment layout
5. Use APD
6. Pay attention to septic and aseptic techniques in performingprocedures

EQUIPMENT

1. Bed / table
2. clean water and soap for hand washing
3. small towels
4. Partus set
5. Heacting set
6. gloves
7. 0.5% chlorine solution
8. placentaplace

MATERIALS

Phantoom pelvis and childbirth, oxytocin and 3 cc syringe, MgSO4 20%, Calcium gluconate, RLsolutions, kateteter Dower, Urine bag , Spuit10 cc

Assessment Early Handling Of Maternal And Neonatal Emergency Cases

No	Actions	Value
	ATTITUDE	
1.	**Welcoming clients politely and kindlypolitely and friendly** 1 Not done 2 Greetings without looking at clientsgreeting 3 Greetings by looking at clients	
2.	**Introducing yourself to clients** 1 Not done 2 Introducing yourself as a midwife without mentioning names 3 Introducing yourself as a midwife byname while shaking hands / giving a friendly touchto the client	
3.	**Responding to client's reaction** 1 Not responding indifferently 2 Responding to client's reaction but not responding appropriately, imperfectlyresponding to 3 client's reaction correctly and politely	
4.	**Confidence** 1 Tested nervous, not making eye contact and voice less clear 2 Look in a hurry and hesitant, lack of confidence 3 Look calm and do it with confidence	
5.	**Tested to give empathy to the client** 1 Not done 2 Give a chance to the client to submit a complaint but did not respond properly 3 Give an opportunity to us lien to submit a complaint and immediately respond properly.	
	Content	
6.	Stay calm, think logically and focus note on the needs of mothers 1. not done 2. done quite right 3. Done properly	
7.	Do not leave the capital without a guardian 1 Not performed 2 Performed by improper 3 done appropriately	
8.	**Ask for help, asking for help to others to take Equipment and medicines needed,** 1 Not done 2 Done improperly 3 Done appropriately	
9.	**If the mother is unconscious, the value of the airway, breathing and circulation** 1 Not done 2 Done incorrectlyright 3 DoneDone	
10.	**If suspected of shock, immediately start the management of shock** 1 Not Done 2 Done improperly 3 Done rightly	
11.	**Put the mother in a lying position with her left side down and feet raised** 1 Not done 2 Done improperlycorrectly 3 DoneDone	
12.	**tight clothes** 1 Not done 2 Done incorrectly 3 Doneappropriately	
13.	**SpeakTalk to patients and help to remain calm**	

	1 Not done 2 Done improperly 3 Done right	
14.	**Done quickly checks, including vital signs.** 1 Not done 2 Done incorrectly 3 Done correctly	
	TECHNIQUE	
15.	**Tested to carry out procedures systematically** 1. Not done 2. Perform procedures but not in sequence. 3. Perform procedures in order / run.	
16.	**Tested to implement infection prevention techniques** 1 Not done 2 Applying infection prevention techniques not right 3 Implementing infection prevention techniques appropriately	
17.	**Tested carrying out communication during examinations** 1. Not carried 2. out Conducting communication but by using language that is not easily understood bypatients 3. Implementing communication with language that is easily understood by patients	
18.	**Maintaining client privacy** 1 Not done 2 Maintaining privacy with speech or demonstrating closing doors / sampiran 3 Maintaining privacy with speech and demonstrating closing doors / sampiran	
19.	**Tested documenting results of actions properly** 1. Not done 2. Documenting results of actions without the identity of the executor 3. Documenting all results of actions with date, time, name and signature executor	

MODULE XIV. STABILIZATION AND REFERENCE MATERNAL EMERGENCY CASE

1. Module Theme : Module Stabilization Practicum and Refer Case Maternal Emergency Case
2. Course / Code : Emergency Maternal Neonatal and BLS / Bd.5.026
3. Number of Credit : 3 Credits (T: 2 Credits, P: 1 Credits))
4. Time allocation : 1 x 170 minutes
5. Semester IV
6. Learning Objectives :

   Students are able to explain the stabilization of neonatal maternal emergency cases.
7. Module overview:

   This module will specifically address practicum referring neonatal maternal emergency cases by conducting demonstrations and independent practice of patient stabilization skills.
8. Student characteristics:

   This module is intended for fourth semester students of D III Study Program in Midwifery Purwokerto Poltekkes Kemenkes Semarang who have participated in learning and graduated in achieving the competency standards of previous courses namely basic Biology and development, basic social and cultural sciences, basic human concepts, midwifery concepts, religion, citizenship, ethicolegal in midwifery practice, midwifery maternity care, basic midwifery skills, communication in midwifery practice, medical science, character education and noble character, practice of basic midwifery skills, midwifery maternity care and newborn, postpartum midwifery and breastfeeding practice, medical education, character education and noble character, practice of basic midwifery skills, midwifery midwifery and newborn care, midwifery and nursing midwifery , neonatal midwifery care, infants, toddlers and pre-school children, public health, health promotion, clinical physiological obstetric practice.
9. Competency Targets:

   Students can explain referring neonatal maternal emergency cases
10. Indicator:

    Students are able to explain referring neonatal maternal emergency cases
11. Learning material : Attached
12. learning strategies: Discussion, questions and answers, demonstrations and independent practice of patient stabilization skills
13. Learning support facilities: LCD, Computer
14. Procedures (Module Usage Instructions):

    a. For Students

    - Students read and understand the learning objectives, practical assignments to be carried out, read references recommended
    - Students practice skills and practices in accordance with the
    - lecturers conduct independent demonstrations of patient stabilization skills and studentspractice independent patient stabilization skills

- Role of Educators / Lecturers: As a facilitator and as a mediator

15. Evaluation methods: questions and answers, post-test

16. Assessment methods: Post-test score scores, response to

17. Bibliography

a. Anik Mary Greece. 2013. *Maternity and Neonatal Emergency Care*. Jakarta: TIM.

b .....2009. *Emergency Care and Complications in Neonates*. Jakarta: TIM.

c. Lilis Lisnawati. 2009. *Current Maternity and Neonatal Emergency Midwifery Care*. Jakarta: TIM.

d. Mochtar, Roestam. 2007. *Synopsis*Obstetrics.Jakarta: EGC.

e. A Practical Guide to Maternal and Neonatal Health Services. 2009. Jakarta: JHPIEGO.

f. Wiknjosastro. 2007. *Obstetrics*. YBPS

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STABILIZATION AND REFERENCE MATERNAL EMERGENCY CASE

Identification of Maternal Reference Planning

After participating in this laboratory practice learning, you are expected to be able to do maternal referral planning. Specifically, after conducting laboratory practice, you are expected to prepare plans for the referral of maternal as follows:

1. Specifies criteria for patients who will be referred
2. Approval for medical action / sheet informconsent
3. Preparation tool danbahan

EQUIPMENT AND MATERIALS

equipment and transport modalities specifically required for referral on time (emergency obstetriccases). Basically, the equipment used for the mother's referral process should have the following criteria:

- Accurate
- Light, small, and easy to carry
- Quality and good functioning
- Rough surfaces to withstand movement due to accelerated dangetaranaccuracy Maintain
- Can be relied on in extreme weather conditions without loss of
- in pressure changes if used in an airplane
- Having its own power source (battery) without disrupting the vehicle's power source

General reference preparations that must be provided when making a referral must be completed, including:

- Mother's reference form (filled in fully, prepare also a backup)
- Stretcher (stretcher)
- Stethoscope
- Thermometer
- Crooked / Vomiting Basin
- Flashlight
- Tensimeter
- Doppler / Funandeskope
- Infusion pump (battery)
- Sterile gloves (3 pairs, various)
- sizesSanitary napkin, preferably special pads Pascalinesterile
- Lubricant/ lubricant
- Antiseptic solution
- Liquid and drugs:Preferred
  - 1000 ml 5% D
  - 1000 ml Ringer Lactate
  - 1000 ml NaCl 0,9% / Asering
  - Colloidal Liquid
  - Plaster
  - Torniket
  - Each pair of intravenous cannulas size 16, 18, and 20
  - Butterfly (cannula IV butterfly type) size 21
  - syringes and
  - alcohol Swabalcohol
  - MgSO41g / ampoule
  - Cagluconas
  - Oxytocin 10 units / ml
  - Ergometrin 0.2 mg / mlml
  - 2 ampoules diazepam 10 mg /ampoule

- Tablets nifedipine 10mg
- Lidocaine 2%
- Epinephrine
- Sulfasatropin
- Diazepam
- Fluid and other drugs according to the case referred to

After the tool is generally available, to make a referral in a neonatal maternal case other additional equipmentis needed:referenced case

Sterile delivery

equipment Adult resuscitation equipment

To facilitate and minimize risks in thereferral travel, the need to refer mothers can be summarized as BAKSOKU (Midwife, Equipment, Family, Letters, Drugs, Vehicles, and Money)

Adult resuscitation equipment

To facilitate and minimize the risks in referral trips, the need to refer mothers can be summarized as BAKSOKU (Midwife, Equipment, Family, Letters, Medicine, Vehicles, and Money).

Ensure that health personnel are able to use the following tools:

- Complete oxygen tube
- Self inflating bag and oxygen tank
- Airway number 3
- Laryngoscope and blade for adults
- Endotracheal tube 7-7.5 mm
- Suction and catheter size 14Fr

Step to Perform Neonatal Maternal Referral

1. Criteria for patients who will refer
   - Hemorrhage
   - Infection / sepsis
   - Preelamsia Weight / eclampsia
   - Obstructed labor / Dystocia
2. Approval for medical treatment / informconsent sheet
   After you find the mother with one of the criteria above, then do the following:
   - Explain to the patient and family about her condition, the dangers that may occur and furtherhelp at the next adequate facility ask the family to sign an informed consent form.
     Complete the referral letter containing: mother's identity, results of examinations, work diagnosis, therapy that has been given, the purpose of the referral, and the names and signatures of health workers who provide services).
   - Other preparations
     - Photocopy of medical records of visits during the visit
     - Photocopy of medical records relating to current conditionssupporting
     - Results ofexaminations Other
     - documents for financing using
     - health insurance Contact the place of referral that will be addressed
   - Family preparation
     Involve 2-3 families of people to take part in trips and fund preparation that may be needed

- Assistance ofmidwives in refer to observasidan provide emergency relief selamaperjalana
- Vehicles

Vehiclesused to refer to the mother in a timely referral must be adapted to the terrain and environmental conditions towards the goal of a referral. The following is an example of a simple ambulance design that can be used to refer to mothers:

Image: Ambulance design to refer (Source: Health service pocket book)

SUMMARY

Your ability to prepare a referral is very important to prevent **3 Delays** in diagnosing, reaching the destination and getting help Make sure, that your preparation has been done correctly as evidenced by the achievement of the assessment has been filled with the number 2 (two) for each item.

Stability Efforts for Maternal Referral

After participating in this laboratory practice learning, you are expected to be able to make efforts to stabilize referral cases for maternal emergencies**.** Specifically, after carrying out this laboratory practice, you are expected to be able to:

1. breathing (freeing airway)
2. Respect forPerformcontrol
3. bleedingDetermine the source of bleeding management for
4. stability Conduct stability of other conditions

After you confirm that the mother has one or more criteria for maternal referral, try to do stability patients before being referred by placing the patient in a warm and comfortable state.

STEP ACTIVITIES

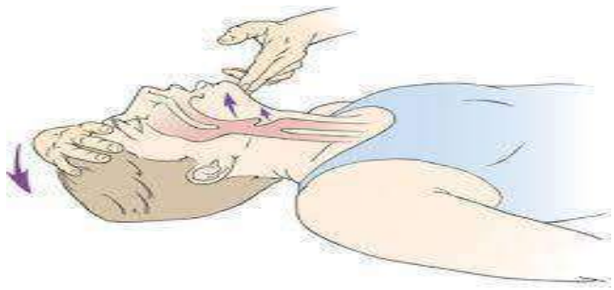
Patient Stability Efforts:

1. *AirWay* : Clean airway and open
2. *Breathing*: Cardiac Frequency 120 -160 times per second breathing
3. *Circulation* : Skin and biblical redness
4. *Drug* : Has given drugs that need

1. Respiratory Handling (breathing*AirWay*)

Using the *technique of Lifting the Chin Press the Forehead* is done forvictim suffered traumato the head, neck and spine:

a. steps which is used:
b. Put your hands on the victim's forehead, use the hand closest to the victim's head.
c. Press the forehead slightly backward with the palm of the hand until the victim's head pushed back.
d. Place the tip of the other finger under the tip of the lower jaw.
e. Raise the chin forward, do this movement simultaneously by pressing the forehead until the victim's head is in the maximum extension position. In infants and young children victims arenot carried out to the maximum but a little extra.
f. Keep your hand on the victim's forehead to keep the head backward.
g. Open the victim's mouth with his thumb pressed against the chin.



The things that must be considered in the *technique of Lifting the Chin Press the Forehead* are as follows:

a. For victims who are still infants should not make maximum head extension movements.
b. Hands do not press on the soft tissue under the chin.
c. Do not use your thumb to liftfinger
d. the head. Keep an eye on the victim's mouth when opening
e. with false teeth. Do not remove theunless disturbing / causing difficulties.

2. Breathing

Make sure the airway is free. Oxygen does not need to be given if the patient's condition is stable and small has a risk of experiencing shock. If the patient's condition is unstable and oxygen is available, give oxygen 6-8 liters per second. What to consider in the installation of oxygen:

a. Observe whether the cannula is blocked / not, the humidifier / humidifier tube is sufficiently filled / notand the volume of oxygen is sufficient / not.
b. Conducting observations / reviewing the patient's condition regularly
c. Documenting procedures in patient records: time of administration, oxygen flow velocity, patient

3. response Circulation

To do a good circulation, it is necessary to do the following:

a. Bleeding Control, which aims to carry out patient stability which can be assessed through whether theskin and lips are reddish (not pale). Bleeding control is done:excessive
   - To preventblood loss
   - Looking
   - Determine the fluid needed
   - Determine the drugs that must be given

b. for sources of bleedingLooking for sources of bleeding, which will be useful to assist management in efforts to stabilize the patient before being referred, which you can learn through the chart below:

Problems	Causes	Management	Information
Pregnancy younger	Abortion	- of observations tight against jumlahperdarahan - Protect with intravenous fluidssebelumdirujuk - Persiapkandonor - (if needed)	 Pictures: positioning the infusion
	Mol a Hydatidosa		
	Ectopic Pregnancy (KET)		
Pregnancy up	Solutio placenta	- of observations tight against jumlahperdarahan - Protect with intravenous fluidssebelumdirujuk - Prepare donor (if needed)	
	Placenta Previa		

Delivery period /Postpartum	Atonia Uteria	- Protect by administering intravenous fluidsanotonic - Giving - massage if unsuccessful internal bimanual compression, external bimanual compression, aortic compression or co ndom catheter before referral	 External Bimanual CompressionCatheter Condom  mage:infusion position
	Tissue (tissue placental)	- Protect by giving intravenous fluids before being referred	
	Traumatic(tear ofthe birth canal)	- Protect by givingintravenous fluids before being referredbefore being referred	
	Thrombin (blood clotting disorders)	- Protect by giving fluidsinfusion sebelumdirujuk	

4. drug or attempts stability of other patients

the purpose of drug delivery and stability of the patient is needed for patient safety on the way to a place ofreference, adapted to the patient's condition can be seen below:

conditions reference	**Signs**	**Management of**
umbilical cor dTumbung / prominent	presence of a rope center in front before the baby is born.	▪ The umbilical cord pressure by the lowest part of the fetus can be minimized by the position of the knee chest or the Trendelenburg. Refer the ▪ mother immediately to a facility that provides the services of the section.  KNEE CHEST POSITION INDEPENDENT

WORK INSTRUCTIONS STABILIZATION SKILLS PATIENTS

OBJECTIVE OBJECTIVE STUDENT BEHAVIOR
Students can:Students

a. Prepare tools and materials for PEB patient stabilization
b. measures Implement procedures and steps to stabilize PEB patients correctly

INSTRUCTIONS
a. Prepare materials and tools needed
b. read and study the work sheet / job sheet that has been provided
c. Follow the instructor's instructions
d. Report the work after completing the work

SAFETY
a. Concentrate on the concentration of the procedure procedures
b. Before the procedure, close the tools and materials
c. Use the tools according to their use
d. SafetyErgonomic equipment layout
e. Use APD
f. Pay attention to septic and aseptic techniques in performingprocedures

EQUIPMENT
a. Bed / table
b. clean water and soap for hand washing
c. small towels
d. Partus set
e. Heacting set
f. gloves
g. 0.5% chlorine solution
h. placeplacenta

MATERIALS
Phantoom Pelvicand placenta, oxytocin and 3 cc syringe, MgSO4 20%, Calcium gluconate, RL solutions, kateteter Dower, Urine bag , Spuit10 cc

CHEC INITIAL ASSESSMENT KLIST (STABILIZATION OF PATIENT)

NO	ITEMS ASSESSED
A.	**ATTITUDE**
1.	**Welcomes the clients with kindness and** 1 not do 2 Giving greetings regardlessclients 3 Providingwith regard greeting clients
2.	**Introduce yourself to the client** 1 Not done 2 Introducing himself as a midwife without naming 3 Introducing yourself as a midwife by saying the name while shaking hands / giving a touchto the client kindly
3.	**Respond to client's reaction** 1 Not respond indifferently 2 Respond to client's reaction but not respond appropriately, imperfectly 3 Respond to client's reaction appropriately and politely
4.	**Confidence** 1 Tested nervous, not making eye contact and voice is unclear 2 Look hasty and hesitant, lack of confidence 3 Look calm and do with confidence
5.	**Tested to give empathy to the client** 1 Not done 2 Give a chance to the client to submit a complaint but do not respond with both 3 provide opportunities to clients k submit a complaint and immediately respond properly.
	Total score: 10
B.	**CONTENT**
6.	**Ask the main problem / complaint that is the reason the patient came to the clinic** 1. Not done 2. Done improperly 3. Done correctly
7.	**Ask a history of the disease / problem** 1. Not done 2. Done incorrectly 3. Done correctly
8 .	**Ask the first date of the last menstruation and menstrual history** 1. not done 2. quite right done 3. done properly
9.	**Ask about pregnancy now** 1. not done 2. quite right done 3. done correctly
10.	**Ask about pregnancy, childbirth and postpartum ago including conditions child** 1. Not done 2. dowith less precise 3. done correctly
11.	**Ask about the disease ever suffered** 1. Not done 2. doneless precisely 3. done withthe right
12.	**Ask about allergies to medications** 1. not do 2. dowith less precise 3. done correctly
13.	**Value general circumstances and to mindless patient is unconscious / coma, convulsions, anxiety, looked in pain** 1. Do not do 2. Do with less precise 3. Done correctly

14.	**mothers face value if pale, flushed, sweating** 1. Not done 2. Doneless precisely 3. Done withthe right
15.	**Value whether rapid breathing, shortness of breath** 1. not done 2. quite right done 3. done correctly
16.	**Free the airway and check vital signs** 1. not do 2. dowith less precise 3. exact done
17.	**Preparation** of PPE (aprons, hats, goggles, masks and pads closed legs) have been used correctly, wash hands and DTT gloves have been installed 1. Not done 2. Done improperly 3. Done appropriately
18.	**Bleeding value of the genitals** 1. Not done 2. Done improperly 3. Done correctly
19.	**Check the skin for cold or fever** 1. Not done 2. Done inappropriately 3. Done with tep at
20.	**Check the pulse whether weak / strong, fast / normal** 1. Not done 2. Done improperly 3. Done appropriately
21.	**Check feet / lower legs for swelling / not** 1. Done 2. Done improperly 3. Done correctly
22.	**Elevate legs / legs below & don't give drinks** 1. Not done 2. Done improperly 3. Done right
23.	**Give oxygen 6-8 liters / minute** 1. Not done 2. Done improperly 3. Done correctly
24.	**Put intravenous RL infusion 1 liter / 20 minutes** 1. Dont do 2. Done with Inadequate 3. Done appropriately
25.	**Prepare references** 1. Not done 2. Done improperly 3. Done appropriately
	Total score: 40
C	**ENGINEERING**
26.	**Tested carrying out procedures systematically** 1 Not done 2 Conducting procedures but not in order. 3 Perform procedures in order / run.
27.	**Tested implementing infection prevention techniques** 1 Not done 2 Applying infection prevention techniques improperly 3 Applying infection prevention techniques appropriately
28.	**Tested carrying out communication during examination** 1 Not carried

	2 out Conducting communication but by using language that is not easily understood bypatients 3 Implementing communication with language that is easily understood by patient
29.	**Maintaining client privacy** 1 Not done 2 Maintaining privacy with speech or demonstrating closing doors / sampiran 3 Maintaining privacy with speech and demonstrating closing doors / sampiran
30.	**Tested documenting the results of actions properly** 1 Not done 2 Documenting the results of actions without the identity of the executor 3 Documenting all results of actions with date, time, name and signature of the executor

TOTAL SCORE = 60