## **CHAPTER 2**

## THEORETICAL BACKGROUND

### 2.1 Theoretical Background of Chepalopelvic Disproportion (CPD)

2.1.1 Anatomy and Physiology Pelvic Bone

Anatomy of Pelvic bone can be seen in the picture below



Image Anatomy of pelvic bone



The bones of the pelvis consists of 3 pieces of the : (1) Pelvic inlet (2) Mid pelvic door and (3) Door underneath the pelvis (pelvic inlet).

2.1.1.1 Pelvic inlet

the inlet to the true pelvis, bounded by the sacral promontory, the horizontal rami of the pubic bones, and the top of the symphysis pubis. Because the infant must pass through the inlet to enter the true pelvis and to be born vaginally, the anteroposterior, transverse, and oblique dimensions of the inlet are important measurements to be made in assessing the pelvis in pregnancy. There are three anteroposterior diameters: the true conjugate, the obstetric conjugate, and the diagonal conjugate. The true conjugate can be measured only on radiographic films because it extends from the sacral promontory to the top of the symphysis pubis. Its normal measurement is 11 cm or more. The obstetric conjugate is the shortest of the three. It extends from the sacral promontory to the thickest part of the pubic bone and measures 10 cm or more. The diagonal conjugate is the most easily and commonly assessed because it extends from the lower border of the symphysis pubis to the sacral promontory. It normally measures 11.5 cm or more. The inlet is said to be contracted when any of these diameters is smaller than normal. The anteroposterior diameters are shorter than normal in the small gynecoid and platypelloid pelvis. The transverse diameter of the inlet is bounded by the inferior border of the walls of the iliac bones and is measured at the widest point. It is normally close to 13.5 cm but may be less in the small gynecoid pelvis and anthropoid pelvis. The oblique diameters of the pelvis extend from the juncture of the sacrum and ilium to the eminence on the ilium on the opposite side of the pelvis. Each oblique diameter measures nearly 13 cm. This dimension is smaller than normal in the small gynecoid and platypelloid pelves. (Mosby's Medical Dictionary, 2009)

#### 2.1.1.2 Mid pelvic door (Pelvic Cavity)

This pelvic floor has the widest size. Middle pelvic clinical measurements can not be obtained directly. There is a narrowing as high as ischial spina, which is important for dystocia after head engagement. The distance between the two

spines is commonly called interspinarum distansia is the smallest pelvic distance of 10.5 cm. Anteroposterior diameter as high as spina isciadica measuring 11.5 cm. The posterior sagittal diameter, the distance between the sacrum and the interspinarum diameter line is 4.5 cm 3.4. (Yeyeh dan lia, 2010)

### 2.1.1.3 Door underneath the pelvis (pelvic inlet)

The underside of the pelvis is not a flat plane but consists of two triangles with the same base of the line connecting the left and right isciadicum tuber. The underside of the pelvis which can be obtained by clinical measurement is the distance between the two isceri tuberosities or tuberum distansia (10.5 cm), the distance from the sacrum end to the middle of the tuberum density or the posterior sagittal diameter (7.5 cm), and the distance between edges below the simplisis to the end of the sacrum (11.5 cm). (Cunningham, et al., 2010)

According Sarwono Prawirohardjo (2010) pelvic bones include :

### 2.1.1.4 Pelvic Major

The Major Pelvis is the pelvic part located above the terminal line, also called the pelvic false. The section located below the terminal line is called the pelvis minor or true pelvis. This final section is a part that has an important role in obstetrics and should be able to be recognized and assessed as best as possible to predict whether or not a baby can pass through.

## 2.1.1.5 Pelvic Minor

This minor pelvic shape resembles a channel having a forward axis (Carus's axis). This axis is classically a line connecting the point of association between the transverse diameter and the vera conjugate at the top of the pelvis with similar points in Hodge II, III, and IV. Up near the Hodge III the axis is straight, parallel to the sacrum, for the next curved forward, corresponding to the curvature of the sacrum. It is important to know when to end the birth with a cunam for the direction of withdrawal of cunam was adjusted with the direction of the axis of the birth canal. Between these two doors there is a pelvic cavity. The size of the pelvic space above and below is not the same. The pelvic floor has the widest size under the pelvic upper door, then narrows to the middle pelvis, and then becomes slightly wider at the bottom. The narrowing is centered, and then becomes slightly wider at the bottom. The narrowing of the middle shoulder is as high as the ischial spine, the distance between the two ischial spines (interspinarum distensia) is normal  $\pm$  10.5.

According to Wagiyo and Putrono (2016) the pelvic type is divided into four, that is Types Of Pelvic :



Anatomi Fisiologi Bentuk Panggul wanita (https://www.lusa.web.id/panggul-wanita-part-3/) (acessed on May 19th, 2018)

- 2.1.1.6 Pelvic gynecoid: Is the most ideal pelvic. The length of the anteroposterior diameter is equal to the diameter of the transverse round. This species is found in 45% of women
- 2.1.1.7 Pelvic android: pelvic common to men. The length of the transverse diameter is close to the sacrum. This species is found in 15% of women.
- 2.1.1.8 Pelvic anthropoid : It has a slightly oval pelvic floor shape like an egg. The length of the anteroposterior diameter is greater than the transverse diameter. This species is found in 35% of women.
- 2.1.1.9 Pelvic platypelloid : The shape narrows the direction of the rear face. The length of transverse diameter is greater than the anteroposterior diameter. This species is found in 5% of women.



# Anatomy and physiology of reproductive system

http://dhamma4u.com/woman-s-anatomy/anatomy-of-female-considerablewoman-s-anatomy/

(acessed on May 19th, 2018)

2.1.2 Anatomy and Physiology of Reproductive System

According to Sofian Amru (2011), organ reproductive system can be divide into 2 parts: external and internal organs. External organ known as the vulva, and consists of parts of the following sections:

- 2.1.2.1 Monsvineries, afat padis located in front of the pubic syphilis. This area is covered hairs at puberty.
- 2.1.2.2 The labia majora (large lips) are two thick fold that form the sides of the vulva, and consists of the skin and fat, and smooth muscle tissue, blood vessels and nerve fibers. Labia majora length of approximately 7.5cm.

- 2.1.2.3 Nimfe or labia minora (small lips) are two small folds of skin between the upper the labia majora. Labia containing erectile tissue
- 2.1.2.4 The clitoris is a small erectile tissue similar to the male penis.It is located in the anterior vestibule
- 2.1.2.5 Vulva is the collective name for the external female genitalia located in the pubic region of the body. The vulva surrounds the external ends of the urethral opening and the vagina and includes the mons pubis, labia majora, labia minora, and clitoris. The mons pubis, or pubic mound, is a raised layer of adipose tissue between the skin and the pubic bone that provides cushioning to the vulva. The inferior portion of the mons pubis splits into left and right halves called the labia majora. The mons pubis and labia majora are covered with pubic hairs. Inside of the labia majora are smaller, hairless folds of skin called the labia minora that surround the vaginal and urethral openings. On the superior end of the labia minora is a small mass of erectile tissue known as the clitoris that contains many nerve endings for sensing sexual pleasure.
- 2.1.2.6 The vestibule is located below the mucous membrane of the vulva, consisting of bulbus vestibuli right and left. Here, there is a major vestibule gland and a minor vestibule gland
- 2.1.2.7 The vagina is an elastic, muscular tube that connects the cervix of the uterus to the exterior of the body. It is located inferior to the uterus and posterior to the urinary bladder. The vagina functions as the receptacle for the penis during sexual intercourse and carries sperm to the uterus and fallopian tubes. It also serves as the birth canal by stretching to allow delivery

of the fetus during childbirth. During menstruation, the menstrual flow exits the body via the vagina.

- 2.1.2.8 Hymen is a membrane that closes the introus of the vagina, usually having a seminular hole, anular, tapisan, septata or berfimbria. If it is not perforated, it is called the athletic hymn or imperforate hymen. Hymen will tear on the koitus, especially after the birth, the rest is called karunkula hymen or the rest of the hymen
- 2.1.2.9 Orifisium uretrae eksternum is the discharge of urine located below the clitoris. In the vicinity of the left and right urinary holes, there is a prenatal skeleton estuary
- 2.1.2.10 The perineum The skin-covered muscular area between the vaginal opening and the anus is called the perineum. It has strong muscles and its own nerve supply, and it helps to support the contents of the pelvic cavity. The hymen is a fold of thin vaginal tissue which partially covers the vaginal entrance in girls. It can be torn during strenuous exercise.

According to Sarwono Prawiharjo (2009), organ reproductive system internal organs, which is located within the pelvis is the vagina, uterus, two ovaries and fallopian tubes (fallopian) :

- 2.1.2.11 Vagina (vagina coitus) is a muscular tube that is coated with a membrane of aparticular type of striped epithalium, drained blood vessels and nerve fibers are plentiful, the length of the vagina from the vestibule to the uterus.
- 2.1.2.12 The uterus (womb) is the organ thick, muscular, pear-shaped, located in the pelvis, between the rectum and bladder in the back in front. The uterus is derived from a combined vertical

ductus paramesonephros. Place the combined corners into a convex dome and form the uterine fundus. The mixture of the ductus is initially incomplete, there is a septum between the lumen.

- 2.1.2.13 The fallopian tubes are a pair of muscular tubes that extend from the left and right superior corners of the uterus to the edge of the ovaries. The fallopian tubes end in a funnel-shaped structure called the infundibulum, which is covered with small finger-like projections called fimbriae. The fimbriae swipe over the outside of the ovaries to pick up released ova and carry them into the infundibulum for transport to the uterus. The inside of each fallopian tube is covered in cilia that work with the smooth muscle of the tube to carry the ovum to the uterus.
- 2.1.2.14 ovaries(ovarian) is a walnut-shaped gland seed, located on the right and left ofthe uterus, fallopian tubes and bound under in the rearbythe broad ligamentof the uterus. The size and appearance of the ovaries depend on both age and the stage the menstrual cycle. In the young adult, they are almond shaped, solid and white in colour, 3 cm long, 1.5cm wide and approximately 1 cm thick. The long axis is normally vertical before childbirth; after this, there is a wide range of variation, presumably due to considerable displacement in the first pregnancy. The ovary is the only intra abdominal structure not to be covered by peritoneum. Each ovary is attached to the cornu of the uterus by the ovarian ligament, and the hilum to the broad ligament by the mesovarium, which contains its supply of vessels and nerves. Laterally, each is attached to the

suspensory ligament of the ovary with folds of peritoneum which become continuous with that over the psoas major.

### 2.1.3 Definition of Chepalopelvic Disproportion (CPD)

According to Verney, (2009) Sevalopelvik disproption (Chepalopelvic Disproportion, CPD), or fetopelvik disproportion is between the size of the fetus and the size of the pelvis ie the size of a particular pelvis is not large enough to accommodate a particular fetus through the pelvis until vaginal birth occurs. Adequate pelvis for the 2.27 kg baby birth canal may be large enough for a 3.2 kg baby may not be large enough with a 3.6 kg baby.

According to Yeyeh dan Lia (2010) CPD or cephalopelvic disproportion is a Abnormalities of the birth can be caused by abnormalities in the hard tissue / pelvic bone, or abnormalities in the pelvic soft tissues, the birth canal is an important process in the birth process consisting of soft birth canal.

According to Anita Lockhart, (2014) CPD or cephalopelvic disproportion is a refers to the narrowing of the birth way. These circumstances include disporposi normal fetal head size with a diameter of pelvic.

#### 2.1.4 Etiology Chepalopelvic Disproportion (CPD)

2.1.4.1 According to Yeyeh dan Lia (2010), etiology Narrow Pelvis or CPD is a Power that is his strength and straining, passage the birth canal, Passanger the deformity and large fetus. 2.1.4.2 According to Anita Lockhart (2014), etiology Narrow pelvis or CPD :

Small pelvis (Main Contributor)

- a. The narrow pelvic top door (When the smallest size for anteroposterior diameter is less than 11cm or maximum transverse diameter of the pelvic top door or only 12cm or less)
- b. The narrow underside of the pelvis (narrowing of intertuberous dysters / transverse diameters less than 11cm in size)
- c. Large baby size, abnormal baby head position, abnormalities in infants and infant malformation

## 2.1.5 Signs and Symptom Cephalopelvic disproportion (CPD)

According to Anita Lockhart (2014) signs and symptoms of CPD (Cephalopelvic disproportion) :

- 2.1.5.1 In the palpation of the abdomen, in primipara the child's head has not fallen after week 36.
- 2.1.5.2 In primipara there is a hanging belly.
- 2.1.5.3 In anamnesa, multiparous labor is difficult.
- 2.1.5.4 There are abnormalities in the location of the old pregnant.
- 2.1.5.5 There are abnormalities of the mother's body shape (midget, scoliosis, limp, and others).
- 2.1.5.6 Birth For longer than usual.

### 2.1.6 Pathofisiology Cephalopelvic disproportion (CPD)

Changes that occur during Cephalopelvic disproportion (CPD) include : The pelvis is considered narrow if the conjugatavera is less than 10 cm or if the transvert diameter is less than 12 cm. Conjugata vera is traversed by a biparietallic diameter of +91/2 cm and sometimes reaches 10 cm, so conjugate vera less than 10 cm can lead to labor difficulties over ordinary hours as much time is spent on the moulage of the child's head. The likelihood is greater that the head is held back by the pelvic floor, resulting in uterine inertia as well as the slowing of the pendulum and the opening of the cervix. The opening disorder is caused by the rupture of the membranes before, the front of the front of the skeleton is less closing on the pelvis, then after membrane rupture the head can not press on the cervix because stuck at the top of the pelvis. On the narrow pelvis the entire head of the child held a hyperflection so that the size of the head through the birth canal is small. (Jitowiyono, 2010)



Pathway Cephalopelvic disproportion (CPD)

2.1.7

(Wida mahmudah (2016), Modification : Yulia)

2.1.8 Medical Management Cephalopelvic disproportion (CPD)
 According Amru Sofian, (2011) Medical Management of Cephalopelvic disproportion (CPD) :

2.1.8.1 Sectio Caesarea

Elective cesarean section is performed on a severe pelvic floor with a term pregnancy, or a real sephalopelvic disproportion. Sectiono can also be performed on mild pelvic constriction if there are complications such as the elderly primigravida and fetal abnormalities that can not be repaired. Secondary cesarean section (after delivery for some time) is done because the probation lab is considered failed or there is an indication to complete the delivery as soon as possible while the vaginum delivery requirement has not been fulfilled.

Sectio Caesaria is surgery to give birth fetal through open the abdominal wall and uterine wall or transabdominal incision of the uterus.(Umi sholikhah, 2011)

Sectio Caesaria is an artificial childbirth where the fetal is born through an incision on abdominal wall and uterus with uterine nerves intact and weighing over 500 grams (Mitayani, 2009).

a. Indication of Sectio Caesaria (SC)

According Rasjidi (2009), there are some indications sectio caesaria, namely as follows :

- 1) Maternal indication
  - a) The absolute narrow pelvis

- b) Failure to deliver normally
- c) Tumors of the birth canal causing obstruction of the birth canal
- d) Stenosis of the cervix or vagina
- e) Placenta previa
- f) Sefalopelvik disporposi (CPD)
- g) The uterine rupture is gifted
- 2) Fetal Indication
  - a) Placement abnormality
  - b) Fetal distress
  - c) Cord prolapse
  - d) The development of delayed infants
  - e) Preventing fetal hypoxia

# 2.1.8.2 Simfisiotomy

This action is done by separating the left and right pelvis on the symphysis. This action is no longer done

# 2.1.8.3 Craniotomy

Conducted In the fetus who died

## 2.1.9 Diagnostic Examination Cephalopelvic disproportion (CPD)

According Amru Sofian, (2011) investigation of Cephalopelvic disproportion (CPD) :

2.1.9.1 Photo of the top door of the pelvis mother in a half-sitting position (THOMS), so that the x-ray tube perpendicular above the pelvic top door

## 2.1.9.2 Lateral photos

Mother in a standing position, the x-ray tube is directed horizontally on the trochanter major from the side Of the two can be clay:

- 1) Transverse diameter
- 2) Distansia interspinarum
- 3) Type of pelvis
- 4) Conjuguta diagonalis + conjuguta vera
- 5) Inside the pelvis
- 6) AP door diameter down
- 7) The posterior sagittal diameter (CALDWELL)
- 8) The shape of the sacrum, spina ischiandika

## 2.2 Nursing Care Management

- 2.2.1 Assesment
  - 2.2.1.1 History Of Healthy
    - a. History Of Curent Disease

In it there are complaints and the state of the patient from home to hospitalized, so given the action based on Palliative (P) is the main factor of complaint, Qualitative (Q) is the quality, Region (R) or the area of pain spread, Safety (S) , Time (T) is the time of the complaint.

b. History Of Previous Disease

Regarding the previous diseases felt and experienced by clients that can affect the current state

c. History Of Family Disease

Is there a family member who has contagious and inherited diseases, such as diabetes mellitus, hypertension, and others.

d. History Period

The first age has menstruation, menstrual period, number of bleeding, cycles, HPHT, estimated delivery, and gestational age

e. History Marriage

Age of the client and husband at the time of marriage, length of marriage, how many times married

f. History of Contraception

Regarding the types of contraceptives used before pregnancy, time and duration of use, problems faced by using contraceptives, types of contraception planned after delivery now

g. History Pregnancy Now

A history of the circumstances of a client during pregnancy now: a complaint during pregnancy, fetal movement, fetal condition, pregnancy check-up, checkpoint, immunization

h. History of Curent Birth Given

The client's history begins to feel the signs of labor and is then examined by the doctor or midwife and the results of the examination are identified, which in case of emergency, immediately referred to the hospital for further action.

- (Rohmah, 2009).
- 2.2.1.2 Physical Examination
  - a. General Condition

Includes the state of the patient, awareness, speech, height, weight and vital signs

b. Head and neck

Asses head shape, hair state, is there any enlargement in the neck, ears sometimes ringing, is there a hearing loss, the tongue often feels thick, spit becomes thicker, teeth easily wobbly, gums easily swollen and bleeding, whether blurred vision, diplopia, Cloudy eye lens.

c. Integumentary system

Skin turgor decreases, the wound or blackish color scars, moisture and shu skin in the area around ulcers and gangrene, redness of the skin around the wound, hair texture and nails.

d. Respiratory system

Are there shortness of breath, cough, sputum, chest pain. In DM patients easily occur infection

e. Cardiovascular system

Tissue perfusion decreases, peripheral pulse weak or decreased, tachycardia / bradycardia, hypertension / hypotension, arrhythmia, cardiomegaly

f. The gastrointestinal system

There are polyphic, polidipsi, nausea, vomiting, diarrhea, constipation, dehydrase, weight change, increased abdominal circumference, obesity.

g. The urinary system

Polyurethane, urinary retention, urinary incontinence, burning sensation or pain during urination, Shape, loche and color, smell and cleanliness

1) Mamae

Shape, nipple state, complaints.

2) Uterus

High Fundus Uteri

(Mitayani, 2009).

### 2.2.1.3 Supportive Investigation

a. Laboratory test results

Examination that includes Blood, Urine, X-ray

b. Drug therapy

Drugs given by the doctor to the client in accordance with the illness

(Mitayani, 2009).

- 2.2.1.4 Nursing Diagnose
  - a. Acute Pain related to agent physical injury (surgery, trauma surgery episiotomy)

### **Characteristic :**

- 1) Changes of appetite
- 2) Changes in blood pressure
- 3) Changes in heart frequency
- 4) Changes in respiratory rate
- 5) Diaforesis
- 6) Behavior distraction
- 7) Expressing behavior
- 8) Face mask
- 9) Attitude protects the pain area
- 10) Focus narrows
- 11) Indication of pain that can be observed
- 12) Change position to avoid pain
- 13) The attitude of the body protects
- 14) Dilated pupils

15) Reporting verbally pain

16) Sleep disturbance

# **Related** :

Injury agen (Biologis, zat kimia, physical, physicalogical) (Nanda Noc-Noc, 2015)

b. Impaired mobility physical releted to Decreased of muscle strength

## Characteristic :

- 1) Decrease reaction time
- 2) Difficulty flipping position
- 3) Perform other activities in lieu of movement
- 4) Dyspnea after the move
- 5) Changes in how it works
- 6) Movement vibrates
- 7) Limited ability to perform fine motor skills
- 8) Limited ability to perform rough motor skills
- 9) Limited range of movement of joints
- 10) Tremor due to movement
- 11) Instability posture
- 12) Slow movement
- 13) Uncoordinated movements

### **Related :**

- 1) Activity intolerance
- 2) Changes in cellular metabolism
- 3) Anxiety
- 4) Cognitive impairment
- 5) Constraints

- 6) Physical unhealthy
- 7) Decreased endurance
- 8) Decreased muscle control
- 9) Decreased muscle mass
- 10) Decreased muscle strength
- 11) Malnutrition
- 12) Muscoloskeletal disorders
- 13) Damage to the integrity of bone structure
- 14) Motion restriction program

(Nanda Nic-Noc 2015)

c. Damage tissue integrity related to Mechanic factor

## **Characteristic :**

Damage to tissues (cornea, mucous membran, intagumen, and subcutan)

### **Related to factor :**

- 1) Circulatory disorders
- 2) Irritant chemicals
- 3) Fluid deficit
- 4) Excess fluid
- 5) Obstacles to physical mobility
- 6) Lack of knowledge
- 7) Mechanical factors
- 8) Nutritional factors
- 9) Radiation
- 10) Temperature extremes

(Nanda Nic-Noc 2015)

d. Risk for bleeding

### **Risk Factors :**

- 1) Aneurism
- 2) Circumcision
- 3) Knowledge deficiency
- 4) Disseminated intravascular coagulopathy
- 5) History crashed
- 6) Gastrointestinal disorders (gastric ulcer disease, polyps, varicose veins)
- 7) Impaired liver function (cirrhosis, hepatitis)
- 8) Inherent coagulopathy (thrombocytopenia)
- 9) Postpartum complications (uterine atony, placental retention)
- 10) Complications related to pregnancy (placenta previa, molar pregnancy, placental abruption)
- 11) Trauma
- 12) Therapeutic side-effects (surgery, drug administration, blood platelet deficiency supply, chemotherapy) (Nanda Nic-Noc 2015)
- e. Risk for infection

## **Risk Factors :**

- 1) Chronic illness
- 2) Insufficient knowledge to avoid pathogen exposure
- 3) Inadequate primary body defense
- 4) Inadequacy of secondary defense
- 5) Inadequate vaccination
- 6) Exposure to environmental pathogens is increasing
- 7) Invasive procedure

8) Malnutrition

(Nanda Nic-Noc 2015)

# f. Risk for ineffective breastfeeding **Characteristic :**

- 1) Inadequate supply of breast milk
- 2) Babies curved to adjust to the breasts
- 3) The baby cries on the breast
- 4) The baby cries in the first hour after breastfeeding
- 5) The baby is fussy within the first hour after breastfeeding
- 6) Infant's inability to latch-on maternal breast properly
- 7) Refused latching on
- 8) Not responsive to other comforts
- 9) Inadequate emptying of each breast after breastfeeding
- 10) Insufficient opportunity for breast sucking
- 11) Less weight gain baby
- 12) Uncomplicated milk intake appears
- 13) Permanent nipples after the first week of breastfeeding
- 14) Continual weight loss of the baby
- 15) Not sucking breasts constantly

### **Related :**

- 1) Deficit knowledge
- 2) Anomaly baby
- 3) Babies receive additional food with artificial nipples
- 4) Breastfeeding discontinuity
- 5) Ambivalent mother
- 6) Maternal anxiety
- 7) Anomaly of mother's breast
- 8) The family does not support

- 9) Couple does not support
- 10) Bad sucking reflexes
- 11) Prematurity
- 12) Breast surgery before
- 13) History of previous breastfeeding failure

(Nanda Nic-Noc 2015)

g. Anxiety related to a threat to self-concept

### **Characteristic :**

- 1) Behavior
- 2) Affective
- 3) Physiological
- 4) Sympathetic
- 5) Parasympathetic
- 6) Cognitive

### **Related :**

- 1) Changes in (Economic status, health, environment, interaction pattern, role function, role status)
- 2) Exposure to toxins
- 3) Related family
- 4) Hereditary
- 5) Infection
- 6) Transmission of interpersonal diseases
- 7) Strees, the threat of death
- 8) Substance abuse
- 9) Threats on (Economic status, health, environment, interaction pattern, role function, role status)
  (Nanda Nic-Noc 2015)

### 2.2.1.5 Nursing Intervention

a. Acute pain related to agent physical injury (surgery, trauma surgery episiotomy)

Goals :

After the action of nursing is expected to acute pain can be reduced

## **Criteria results :**

- 1) Reported that pain is reduced with pain management techniques
- Be able to recognize pain (scale, intensity, frequency and pain sign)
- 3) Express the feeling of comfort after the pain is reduced.

### **Intervention and Rational :**

Ask the patient to describe the pain and examine the physical symptoms that identify the pain.

Rational : Continuous review allows modification of the necessary treatment plan.

- 2) Give the recommended medication to reduce the pain.Rational : to reduce pain
- 3) Check the effectiveness of treatment after 30 minutes.Rational : to monitor pain reduction and establish the level of trust required for therapeutic relationships
- Ask the patient to help determine the goal of pain reduction (including reduced reliance on analgesics) and develop a plan for pain control.

Rational : this action gives a sense of control to the patient

5) Teach patients alternative pain control techniques, such as relaxation.

Rational : to reduce dependence on analgesics.

- 6) Collaboration with doctor giving of analgesics as indicated Rational : These actions improve health and reduce pain Analgesics are given to reduce pain
- b. Impaired mobility physical releted to Decreased of muscle strength

Goals :

After the nursing action in the client obstacle of mobility physical can reduced

## **Criteria Result :**

- 1) Increasing of client physical activity
- 2) Understand about the purpose from increasing mobility
- 3) Client scale activity became 1 (independent)
- Client muscle scale became 5 (can move freely and move against prisoner

### **Intervention and Rational :**

1) Asses client ability in mobilization

Rational : Identifying barriers to mobility guides design of an optimal treatment plan

 Give helping tools if client need (such as walker or wheel chair)

Rational : Using helping tools can help client on mobilization

3) Asses client activity scale

Rational : Know client activity limit and understanding the particular level, guides the design of best possible management plan

4) Asses client muscle strength

Rational : Restricted movement influences the capacity to perform most activities of daily living. Safety with ambulation is a significant matter. Determines strengths or insufficiency and may give information regarding recovery. This helps out in preference of actions since different methods are used for the following: flaccid and spastic paralysis

- 5) Giving information about the importance of mobilization Rational : Exercise can make client mobilization improve
- c. Damage tissue integrity related to Mechanic factor **Goals :**

After the nursing action in the client damaged tissue integrity can reduced

# Criteria results :

- 1) Normal tissue perfusion
- 2) There is no infection signs
- 3) Tissue thickness and texture on normal range
- Showing understanment on skin repairing process and prevent on continous injury
- 5) Showing on process wound healing (on inflammation phase)

## **Intervention and Rational :**

1) Watch skin to keep clean and dry

Rational : Wet skin can causing irritation and another infection

2) Do wound treatment with sterile dressing

Rational : Unsterile dressing wound can me wound healing taking more time

- 3) Monitor skin if there is any rednessRational : Redness is a sign of infection
- 4) Give position to reduce wound pressureRational : Excessive activity can make the wound taking more time to healing
- 5) Collaboration with nutritionist for giving diet high calori high proteinRational : The right diet can make wound healing process

easier

d. Risk for bleeding

# Goals :

After the nursing action, client risk for bleeding never happen

# **Criteria results :**

- 1) Lochea does not smell rotten
- The color change must be in accordance with the wound healing level
- Lokhea Rubra. Lokhea is a fresh red color like menstrual blood because it contains a lot of blood, expenditure immediately after delivery to 2 days post partum of less
- Lokhea Sanguinolenta. Lokhea is red yellow contains blood and mucus due to the influence of blood plasma, spending on day 3-7 post partum day
- Lokhea Serosa. Lokhea is brownish yellow or serum, out on 7-14 post Partum.

# **Intervention and Rational :**

1) Monitor uterine involution and lochea expenditure

Rational : Uterine infections inhibit involution and prolonged exposure of lokhea

- 2) Asses the signs of weakness, coldness, anorexia, soft uterine contractions, and pelvic painRational : The signs are an indication of the occurrence of bacteremia, an undetectable shock
- Observe the possibility of infection elsewhere, such as respiratory infections, mastitis and urinary tract Rational : Infection elsewhere may aggravate the state of the client
- 4) Performed vulva hygiene and other personal hygiene Rational : prevent infection
- Collaboration with doctor giving antibiotics as indicated Rational : Antibiotics suppress or eliminate the development of bacteria in the body
- e. Risk for infection

## Goals:

After the nursing action in the risk for infection never happen

# **Criteria results:**

- 1) Clients are free from signs and symptoms of infection.
- Describes the process of transmission of disease factors that affect transmission and management.
- 3) Shows the ability to prevent the onset of infection.
- The number of leukocytes within normal limits, indicating healthy life behavior.

## **Intevention and Rational :**

- 1) Minimize the risk of infection in patients, such as:
  - a) Wash hands before and after treatment. Hand washing is the single best way to prevent pathogen transmission
  - b) Using gloves to maintain asepsis when providing direct treatment.

Rationale : the glove can protect the hand when handling the wound is bandaged or perform various actions.

2) Asses sign and symptom for infection

Rational : After surgery can be a sign of pulmonary complications, wound infection, urinary tract infections.

- 3) Observation infetion sign of wound areaRational : Knowing the wound and its development
- Perform wound care in accordance with the rules of hospital and doctor program doing wound treatment with sterile dressing.

Rational: this action can identify pathogens and serve as guidelines for antibiotic therapy.

- 5) Provide health education to family and clients about the factors that increase the occurrence of infectionsRational : Family of client and clients can know the symptoms of wound infection
- 6) Collaboration with doctor giving antibiotics as indicated
  Rational : Antibiotics suppress or eliminate the development
  of bacteria in the body

# f. Risk for ineffective breastfeeding Goals :

After the nursing action in the risk for ineffective breastfeeding client knows the benefits and the correct way to breastfeed.

# Criteria results :

- 1) Breastfeeding Arrangement: Infant: appropriate infant attachment and sucking process from mother's breast to obtain nutrition during first 3 weeks of breastfeeding
- Stability of Breastfeeding, MOM : Mother stability to make babies adhere properly and breastfeeding and mother's breast to obtain nutrition during the first 3 weeks of breastfeeding
- Breastfeeding maintenance: Breastfeeding continuity to provide nutrition for baby / todler
- 4) Progressive discontinuity of breastfeeding
- 5) Breastfeeding Knowledge: the level of understanding shown to recognize lactation and infant feeding through breastfeeding process of the mother recognizes hunger cues from the infant immediately indicates satisfaction of breastfeeding the mother does not experience tenderness on the nipple recognizing signs of decreased milk supply

### **Intervention and Rational :**

 Assess client knowledge and experience about breastfeeding before.

Rational : Assist in identifying current needs and developing maintenance plans.

 Asses putting client, encourage clients to see nipples after breastfeeding.

Rational : Early identification and intervention may prevent or limit the occurrence of cuts or nipples without regard to duration of breastfeeding.

- Determine the support system available to the client, and the attitude of spouse or family.
- Rational : Having sufficient support increases the chances for successful breastfeeding experience.
- 5) Provide information on the benefits of breastfeeding, nursing and breast care and the factors that facilitate or interfere with the success of breastfeeding.

Rational : Helps ensure adequate milk supply, prevents wound nipples or ruptures, provides comfort and makes breastfeeding mothers a role.

 Demonstrate and review breastfeeding techniques. Note the position of the baby during breastfeeding and duration of breastfeeding.

Rational : The right position usually prevents putting sores regardless of duration of breastfeeding.

7) Give a special breast nipple shield for lactating clients with putting in or flat. Encourage the use of ice packs before nursing and nipple exercises by rotating between the thumb and middle finger and using Hoffman techniques.

Rational : Lactation bowl / breast protector, ice-ice exercises help make the nipples more erect, Hoffman technique releases adhesiveness that causes nipple inversion

# g. Anxiety related to related to a threat to self-concept

## Goals :

After the action of nursing is expected to Anxiety can be reduced **Criteria Result :** 

- 1) The client is able to identify and express the anxiety symptoms
- Identify, expose and demonstrate techniques to control anxiety.
- Posture, facial expressions , body language and activity levels indicate less anxiety

## **Intervention and Rational :**

- Observations of general conditions and vital sign Rational : Recognize and facilitate the nursing actions
- 2) Identify the level of anxietyRationale : Know patient's anxiety level.
- 3) Use the approach that calms the clientRational : Increase bhsp
- 4) Accompany the patient to provide security and reduce fear Rational : Reduce patient anxiety
- 5) Provide factual information about the diagnosis, prognostic action.

Rational : helps reduce anxiety levels