

MIDWIFERY CARE FOR A LADY IN LABOR, Mrs. "Y" G5P4P0, 38 WEEKS AND 1 DAY GESTATION WITH PREMATURE RUPTURE OF MEMBRANES (PROM)

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A B S T R A C T

Background: Childbirth is a physiological process occurring in term pregnancy; however, it may be accompanied by complications such as Premature Rupture of Membranes (PROM), which is the rupture of the amniotic membranes before the onset of labor. PROM may increase the risk of infection, neonatal asphyxia, and preterm birth, requiring appropriate and comprehensive management. **Purpose:** To provide intranatal midwifery care for Mrs. "Y", G5P4A0, at 38 weeks and 5 days of gestation with PROM at Kanapa-Napa Public Health Center using the seven-step Varney midwifery management approach. **Sample/Subject:** Mrs. "Y", G5P4A0, at 38 weeks and 5 days of gestation with Premature Rupture of Membranes. **Method:** A descriptive method with a case study design was used through the collection of primary and secondary data, which were analyzed and presented based on the seven-step Varney midwifery management approach and SOAP documentation. **Results:** The midwifery care included data assessment, determination of the actual diagnosis, identification of potential problems, planning, implementation, and evaluation. Management included monitoring maternal vital signs, maternal and fetal conditions, infection prevention, and observation of labor progress. The labor progressed normally, the baby was delivered spontaneously in good condition without complications, and no discrepancies were found between theory and practice. **Conclusion:** Intranatal midwifery care for Mrs. "Y" with PROM was provided comprehensively according to midwifery care standards, with favorable outcomes for both mother and baby.

INTRODUCTION

Labor is a physiological process that occurs at the end of pregnancy and is characterized by uterine contractions that cause changes in the cervix in the form of thinning and opening, followed by the descent of the fetus until the baby and placenta are born. (Fitriyani *et al.*, 2024). The birth process generally takes place during full-term pregnancy when the fetus is able to live outside the womb and requires monitoring to ensure the condition of the mother and fetus remains optimal. (Rejeki, 2020). Although a physiological process, labor can develop into a pathological condition if accompanied by obstetric complications that require immediate treatment. One common complication is Premature Rupture of Membranes (PROM), which is the rupture of the amniotic sac before labor begins. (Dunn *et al.*, 2023). PROM is a condition that requires attention because it can increase the risk of various maternal and neonatal complications.

Premature rupture of membranes (PROM) is the rupture of the amniotic sac before labor begins. If it occurs before 37 weeks of gestation, it is called preterm premature rupture of membranes (PPROM). PROM can occur due to various factors that weaken the amniotic membranes, including infection, inflammation, excessive uterine distension, and other mechanical factors (Siegler, Weiner and Solt, 2020). Globally, PROM is estimated to occur in approximately 5–15% of pregnancies and is a significant issue due to its association with preterm birth, intrauterine infection, and increased maternal and neonatal morbidity and mortality. Obstetric and gynecology clinical guidelines also state that term PROM can occur in approximately 6.46–15.6% of term pregnancies, while PPRM is associated with an increased risk of perinatal infection, preterm birth, and umbilical cord compression.

The urgency of PROM management is related to the significant impact it can have on the mother and baby if not managed appropriately. In the mother, PROM can increase the risk of infections such as chorioamnionitis and sepsis, while in the fetus, it can cause umbilical cord compression, infection, preterm birth, and impaired oxygenation, potentially leading to neonatal asphyxia. (Nujoom *et al.*, 2025). These risks become increasingly important in the context of maternal health because maternal mortality remains a global health problem, with more than 700 women dying every day by 2023 from causes related to pregnancy and childbirth, most of which are preventable (World Health Organization, 2025). In Indonesia, the maternal mortality ratio according to WHO estimates for 2023 still reaches 140.5 per 100,000 live births, so improving the quality of services

during pregnancy and childbirth remains an important need (World Health Organization, 2025). This situation demonstrates that early detection, monitoring of maternal and fetal conditions, infection prevention, and appropriate decision-making in cases of PROM are crucial in preventing maternal and infant morbidity and mortality.

In Indonesia, PROM is also a childbirth complication that requires attention due to its still relatively high prevalence. Analysis of 2018 Basic Health Research (Riskesdas) data shows that PROM is a childbirth complication, accounting for approximately 5.6% of women aged 10–54 years. In Southeast Sulawesi, the incidence of PROM, based on data used in previous research, was recorded at 3.12% of women giving birth in 2021, while in Baubau City, the incidence was reported to reach 6.79% in 2022 (Almunawarah *et al.*, 2023). Comprehensive management of PROM requires monitoring vital signs, fetal condition, infection prevention, and observing labor progress according to the clinical conditions of the mother and fetus. In addition to medical and obstetric management, supportive approaches such as the use of a gym ball or birth ball can help the mother achieve a more comfortable position and support labor progress. Research by Fatimah *et al.* (2024) showed that the use of a gym ball can help accelerate the progress of the first stage of labor. Other case studies have also shown that comprehensive midwifery care for mothers experiencing PROM can result in spontaneous labor with good maternal and fetal health (Fatimah *et al.*, 2024).

Based on data from the Kanapa-Napa Community Health Center, in 2024 there were 20 cases of labor with Premature Rupture of Membranes, while from January to January 2025 there were 8 cases of PROM. These data indicate that PROM is still found in delivery services at the Kanapa-Napa Community Health Center, so that appropriate, systematic, and appropriate midwifery care is needed for the condition of the mother and fetus. Although various studies have discussed the incidence and management of PROM, reports on the implementation of direct intranatal midwifery care for mothers with PROM at the Kanapa-Napa Community Health Center are still limited, so there is a gap between general research evidence and documentation of the implementation of care in local cases. Therefore, this case study is important to describe the implementation of midwifery care management for mothers giving birth with PROM and to evaluate the suitability between theory and practice of midwifery services. Based on this description, the author is interested in conducting a case study entitled "Midwifery Care for Mrs. 'Y' G5P4A0, 38 Weeks and 1 Day Gestational Age with Premature Rupture of Membranes (PROM) in the Delivery Room of the Kanapa-Napa Community Health Center."

METHOD

This final project report uses a descriptive method with a case study approach. The case study was conducted to describe in depth and systematically the implementation of midwifery care for women giving birth with Premature Rupture of Membranes (PROM) in the delivery room of the Kanapa-Napa Community Health Center, Central Buton Regency. Care implementation utilized Varney's 7-step midwifery management approach, which includes baseline data collection, baseline data interpretation, identification of actual diagnoses or problems, identification of potential diagnoses or problems, identification of immediate intervention needs, care planning, care implementation, and evaluation. The client's condition during the care delivery process was documented in a SOAP (Subjective, Objective, Assessment, and Plan) format to determine the response to the care provided.

This case study was conducted in the delivery room of the Kanapa-Napa Community Health Center, Central Buton Regency, from December 2, 2025, to January 23, 2026. The subject of this case study was Mrs. "Y" G5P4A0, 38 weeks and 1 day gestation with Premature Rupture of Membranes (PROM), received intranatal obstetric care in the delivery room of the Kanapa-Napa Community Health Center. Subject selection was based on suitability for the case focus of this report, namely a mother giving birth with PROM at term.

The data used in this case study consists of primary and secondary data. Primary data were obtained directly from the subject through interviews, observations, and physical examinations to obtain information regarding the mother's subjective and objective condition. Secondary data were obtained through a documentary study of health records and service documents available at the Kanapa-Napa Community Health Center, such as medical records, KIA books, mother cards, and cohort registers of pregnant women, those giving birth, postpartum women, and newborns. The use of primary and secondary data was carried out to obtain comprehensive information regarding the mother's condition, the delivery process, the procedures administered, and the development of the mother and baby's condition during care.

Data collection techniques included interviews, observation, physical examination, and documentation studies. Interviews were conducted directly with Mrs. "Y" using a midwifery care assessment format to obtain data regarding her identity, chief complaint, medical history, obstetric history, pregnancy history, and other information related to the mother's condition. Observations included the mother's general condition, vital signs, uterine contractions, vaginal discharge, fetal condition, and labor progress. A physical examination was conducted systematically to obtain objective data regarding the mother's condition through inspection, palpation, auscultation, and percussion as needed, as well as supporting or laboratory tests if available and necessary. Documentation studies were conducted by reviewing healthcare documents and Mrs. "Y"'s medical records related to her pregnancy, labor, and the baby's condition.

Data analysis was conducted descriptively using Varney's 7-step midwifery management approach. Data obtained through interviews, observation, physical examination, supporting tests, and documentation were collected and interpreted to determine the actual diagnosis, accompanying problems, potential problems, and the need for immediate intervention. A care plan was then developed, implemented according to the mother's condition and needs, and then evaluated based on the progress of the mother and baby. The results of the care development were documented using the SOAP format to systematically describe changes in the client's condition over time.

Data presentation in the final project report was descriptive and systematic, based on Varney's 7-step midwifery care management process and SOAP progress notes. The data were presented in a narrative form that described the assessment results, diagnosis, potential problems, immediate needs, planning, implementation, and evaluation of midwifery care for Mrs. "Y" with PROM. This presentation was used to illustrate the alignment between midwifery care theory and its application to the case encountered in the field.

The case study was conducted in accordance with ethical principles of research and health services to safeguard the rights, safety, comfort, and confidentiality of the subjects. Prior to data collection and care delivery, the subjects were given an explanation of the purpose and process of the case study and were asked to provide informed consent. The subjects' identities were kept confidential by using the initials Mrs. "Y" and by not including any personal identifying information that could reveal their identity. All information and data obtained during the implementation of the case study is used only for the purposes of preparing the final assignment report and is kept confidential.

RESULTS & DISCUSSION

Subjective Data

The results of the assessment on Mrs. "Y" on December 3, 2025, at the Kanapa Napa Community Health Center revealed that she was a 35-year-old woman, married once to her husband for approximately 10 years, had a high school education, and worked as a housewife, while her husband worked as a fisherman. She came to the delivery room complaining of lower abdominal pain that radiated to the back and was accompanied by mucus discharge mixed with blood. She stated that the abdominal pain began on December 2, 2025, at 10:00 a.m. WITA (Central Indonesian Time), and that her water had broken before labor. She stated that fetal movement was still active and felt strongly, especially in the right side of her abdomen. Based on her pregnancy history, she stated that this was her fifth pregnancy and had never experienced a miscarriage. The mother underwent two prenatal checkups at the Kanapa Napa Community Health Center, felt fetal movement since 20 weeks of pregnancy, and received the TT3 immunization on December 1, 2025. The mother stated that she had never taken any medications without a doctor's prescription and planned to deliver at the community health center.

The mother stated that she had no history of heart disease, asthma, tuberculosis, diabetes mellitus, hypertension, malaria, or HIV/AIDS, either in herself or in her family. Biologically, the mother stated that her last meal was a moderate portion of rice and fish, and her last drink was a glass. Her appetite decreased due to contractions. She stated that she last slept at 10:00 PM WITA (Central Indonesian Time) complaining of intermittent abdominal pain and that she rested during the day. During the assessment, the mother was unable to rest properly due to the contractions. Psychologically, the mother stated that she was ready for labor but felt anxious. Her relationship with her husband and family was harmonious, family decisions were made jointly by her husband, and all the necessary supplies for delivery and delivery had been prepared. Spiritually, the mother and her family continued to practice religious services and pray for the safety of the mother and baby.

Objective Data

Examination results indicated the mother's general condition was good, with *compos mentis* consciousness. Vital signs showed a blood pressure of 110/80 mmHg, a pulse of 80 beats/minute, a respiratory rate of 20 breaths/minute, and a temperature of 36.5°C. Physical examination revealed no facial edema or *chloasma gravidarum*, pink conjunctivae, white sclerae, moist oral mucosa, and fresh lips. The neck showed no lymph node swelling or jugular vein enlargement. The breasts appeared symmetrical, with hyperpigmented areolae, prominent nipples, and colostrum. The abdomen appeared enlarged for gestational age, and there were no surgical scars. A Leopold's examination revealed a fundal height of 32 cm, or approximately three finger widths below the xiphoid process. The fetal back was to the left, the head was present, and a Leopold IV examination revealed the fetal head had entered the pelvic inlet divergently. The abdominal circumference was 101 cm with an estimated fetal weight of approximately 3,232 grams. There were three uterine contractions in 10 minutes, each lasting approximately 40 seconds, and the fetal heart rate was clearly audible at a frequency of 145 beats/minute.

A genital examination revealed a normal vulva and vagina, a thinning portio, a 2 cm cervical dilation, approximately 30% effacement, ruptured membranes, a cephalic presentation, and a Hodge II–III head descent. A normal pelvic impression was present, and there was mucus discharge mixed with blood. An extremity examination revealed symmetrical hands and feet, no edema or varicose veins, and clean, pink nails. At the next labor progress examination, on December 4, 2025, at 12:00 WITA, the cervix had reached 6 cm dilation, with a Hodge II–III head descent. Then, at 4:00 PM WITA, the cervix was 10 cm dilated, the head descended to Hodge IV, the membranes had broken, and the amniotic fluid appeared clear. The fetal heart rate remained within normal limits, and no signs of fetal distress were found.

Assessment

Based on the assessment results, a diagnosis was made for Mrs. "Y" G5P4A0, gestational age 38 weeks 1 day, intrauterine, singleton, viable, longitudinal lie, left dorsal, cephalic presentation, presenting fetus divergently into the pelvic inlet, maternal and fetal condition good, first stage of labor with premature rupture of membranes. This diagnosis was based on the mother's obstetric history, which indicated her fifth pregnancy with four deliveries and no previous abortions, her LMP dated March 11, 2025, abdominal palpation showing a single fetus in a longitudinal lie and cephalic presentation, and clear and regular fetal heart rate within normal limits. The presence of abdominal pain radiating to the back, regular uterine contractions, bloody mucus discharge, cervical dilation, and ruptured membranes indicated that the mother was in first stage of labor with PROM. The general condition of the mother and fetus was good, so there were no potential diagnoses or emergency procedures requiring immediate collaboration.

Management

Midwifery care for Mrs. "Y" was provided by explaining to the mother and family the examination results, indicating that the mother and fetus were in good condition and that she was in the first stage of labor with her membranes having broken. The mother was encouraged to empty her bladder to provide comfort and assist with the descent of the presenting part of the fetus. Vital signs, the frequency and duration of contractions, and the fetal heart rate were monitored regularly to assess the condition of the mother, fetus, and the progress of labor. The mother was also given support and motivation to remain calm during labor.

To help the mother adapt to labor pain, she was explained the causes of pain and taught relaxation techniques and breathing control, such as inhaling through the nose and exhaling through the mouth during contractions. The mother was encouraged to mobilize by walking between contractions and doing exercises using a gym ball. The gym ball exercises were performed several times for approximately 30 minutes, depending on the mother's condition. The mother was also encouraged to eat and drink between contractions to maintain energy during labor. The progress of labor was monitored through internal examinations and recorded on a partograph.

During the examination on December 3, 2025 at 08.00 WITA, the cervical dilation was 2 cm with the membranes having broken and the head presentation. Furthermore, on December 4, 2025 at 12.00 WITA, the cervical dilation reached 6 cm with the head descending to Hodge II–III. At 16.00 WITA, the cervical dilation was complete at 10 cm with the head descending to Hodge IV. During monitoring, the mother's condition remained good with blood pressure of 120/80 mmHg, pulse 90

beats/minute, respiration 20 breaths/minute and temperature 36.7°C, while the heart rate was 142 beats/minute. The mother was able to adapt to the pain and received support from her husband and family.

Entering the second stage of labor, the mother reported increasing abdominal pain and fatigue. The examination revealed a protruding perineum, open vulva and anus, and complete cervical dilation of 10 cm, with the head descending to Hodge IV. The mother was informed that the dilation was complete and the fetus was in good condition, and was then instructed to push during contractions. Delivery equipment, resuscitation equipment, medications, and supplies for both mother and baby were ensured to be readily available. The delivery was performed according to procedure, with adherence to infection prevention principles. After the head was delivered, the umbilical cord was checked for entanglement, and the baby's shoulders and body were delivered. The baby was born on December 4, 2025, at 4:35 PM WITA. She was a girl, weighing 2,800 grams, with an Apgar score of 8/10. The baby was placed on the mother's abdomen, and skin-to-skin contact was provided between the mother and baby.

During the third stage, the mother reported still experiencing abdominal pain and felt a lot of blood coming out of the birth canal. The examination showed a well-contracted uterus, a firm and round fundus, a sudden and brief release of blood, and an increase in the length of the umbilical cord. Active management of the third stage was performed with intramuscular administration of 10 IU of oxytocin, controlled cord traction, and fundal massage after delivery of the placenta. The placenta was then delivered intact along with its membranes, and the birth canal was examined. The examination revealed no tears or ruptures in the birth canal, and uterine contractions remained good.

During the fourth stage, the mother reported still experiencing abdominal pain and fatigue. The examination showed a complete delivery of the placenta and membranes, good uterine contractions, a uterine fundus one finger-width below the navel, approximately 50 cc of blood loss, blood pressure of 110/80 mmHg, pulse rate of 80 beats/minute, respiration rate of 20 breaths/minute, and a temperature of 36°C. Uterine contractions, fundal height, bladder function, and bleeding were monitored periodically. During the two-hour monitoring, uterine contractions remained good, the fundus remained one finger-width below the navel, the bladder was empty, and the amount of bleeding gradually decreased. The baby was then physically examined, weighed, and measured, and given eye ointment, vitamin K, and hepatitis B immunization as per procedure. The mother was given food and drink, cleaned, and changed into clean, dry clothing. Both mother and baby were in good condition, and there were no signs of complications during the fourth stage of labor.

DISCUSSION

Subjective Data

The assessment of Mrs. "Y," 35, G5P4A0, who came to the Kanapa Napa Community Health Center, revealed that she complained of watery discharge from the birth canal before full dilation. The discharge was clear and continuous. She also experienced abdominal pain radiating to the back and regular, increasingly strong contractions. The assessment included the chief complaint, menstrual history, current pregnancy, previous birth history, medical history, basic needs fulfillment patterns, and obstetrical condition to obtain complete data for diagnosis and care.

Based on the assessment, gestational age was recorded based on the LMP of March 11, 2025, and the HTP of December 18, 2025, using Naegele's rule. The pregnancy was in the third trimester with a single, viable, intrauterine fetus, with an elongated site, and a cephalic presentation. Gestational age is calculated using Naegele's rule by adding seven days to the LMP, subtracting three months, and then adding one year to determine the estimated due date.

In Mrs. "Y"'s case, factors associated with the occurrence of PROM were maternal age 35 years and high parity. Maternal age over 35 can increase the risk of PROM due to decreased elasticity of reproductive tissue, making the amniotic membranes more susceptible to weakening. Furthermore, high parity can affect the strength of the amniotic membranes due to repeated uterine stretching in previous pregnancies (Nurkhayati and Hasanah, 2020).

Objective Data

Examination of Mrs. "Y" showed a good general condition with *compos mentis* consciousness. Vital signs were blood pressure 110/80 mmHg, pulse 80 beats/minute, respiration 20 breaths/minute, and temperature 36.5°C. Abdominal examination revealed a uterine fundal height appropriate for gestational age, an elongated site, cephalic presentation, and a fetal heart rate of 145 beats/minute.

Internal examination revealed a cervical dilation of 2 cm, effacement of 40%, the head at Hodge's I position, and rupture of membranes.

Examination results indicated that the general condition of the mother and fetus remained good, with no signs of infection or obstetric emergency. These conditions are in accordance with the physiological limits of vital signs of pregnant women in the third trimester, namely blood pressure of around 110/70–130/80 mmHg, pulse 60–100 times/minute, respiration 16–24 times/minute, and temperature 36.5–37.5°C. (Manuaba, 2020)..

Assessment

Based on subjective and objective data, the obstetric diagnosis for Mrs. "Y" is G5P4A0, gestational age 38 weeks 1 day, intrauterine, singleton, viable, elongated site, cephalic presentation, good maternal and fetal condition, first stage of labor with Premature Rupture of Membranes (PROM). The diagnosis of PROM is supported by the presence of continuous amniotic fluid loss before full dilation and by an internal examination indicating ruptured membranes. Premature Rupture of Membranes is the rupture of the membranes before labor is complete and can increase the risk of intrauterine infection if not managed appropriately (Merida *et al.*, 2023).

In Mrs. "Y," there were no signs of fetal distress or infection, such as fever, smelly amniotic fluid, or an abnormal fetal heart rate. However, PROM carries the potential for infection in both the mother and the fetus, as ruptured membranes can provide a pathway for microorganisms to enter the uterine cavity. The risk of infection increases if the interval between rupture of membranes and delivery is more than 24 hours (Baptista, Fernandes and Soares, 2021).

Because the mother and fetus remained stable, there were no indications for emergency intervention or immediate collaboration. Care focused on monitoring the condition of the mother and fetus, monitoring the progress of labor, preventing infection, and supporting labor.

The assessment of Mrs. "Y" indicated that her membranes had ruptured before labor was complete, accompanied by uterine contractions and progressive cervical dilation. This finding aligns with the research of Almunawarah *et al.* (2023), which described pathological intranatal midwifery care for women giving birth with Premature Rupture of Membranes (PROM), where the diagnosis was based on the passage of amniotic fluid before labor was complete and supportive obstetric examination results. In Mrs. "Y"'s case, despite PROM, the mother and fetus remained in good condition, so care focused on monitoring vital signs, fetal condition, labor progress, and preventing complications, especially infection. This demonstrates the need for systematic assessment and management of women giving birth with PROM to detect potential complications early and ensure a safe delivery for both mother and baby.

Management

Midwifery care for Mrs. "Y" was carried out with the aim of maintaining the good condition of the mother and fetus, preventing complications of PROM, and supporting the progress of labor. The care plan included monitoring vital signs, contractions, fetal heart rate, and the progress of dilation using a partograph, meeting nutritional and fluid needs, psychological support, mobilization, and providing education on relaxation and breathing techniques.

In addition to standard care, Mrs. "Y" was given non-pharmacological therapy in the form of using a gym ball with pelvic rocking movements. The movements involve moving the pelvis forward, backward, right, left, and slowly rotating on the ball. The use of a gym ball can help expand the pelvic cavity, increase maternal comfort, assist with descent of the fetal head, and support the progress of cervical dilation (Syafaiz *et al.*, 2025).

The use of gym balls during labor is supported by Dewi *et al.* (2024) who stated that the use of gym balls can help speed up the labor process, increase comfort, and reduce pain during the first stage. In addition, the upright position and active movement during the use of gym balls can help speed up cervical dilation and the descent of the fetal head (Dewi *et al.*, 2024)

Implementation was carried out by regularly monitoring the condition of the mother and fetus. Monitoring results showed blood pressure of 120/80 mmHg, pulse 80 beats/minute, temperature 36.7°C, contractions twice in 10 minutes with a duration of 20–25 seconds, and a fetal heart rate of 140 beats/minute. The mother was given an explanation of her condition and taught relaxation and breathing techniques during contractions.

Gym ball therapy was conducted in six sessions, from 8:30 a.m. WITA to 1:00 p.m. WITA the following day, each lasting 30 minutes. During the procedure, the mother appeared more relaxed and

comfortable. Mobilization and an upright position during the gym ball helped increase pressure on the presenting part of the fetus on the cervix, thus supporting the process of head descent and cervical dilation (Rufaindah, 2024).

The evaluation results showed that the condition of the mother and fetus remained stable throughout labor. Vital signs were within normal limits, and the fetal heart rate was 142 beats/minute. Labor progressed progressively until full dilation, with no signs of infection or fetal distress. These findings indicate that monitoring and management of PROM were effective (Wahyuni *et al.*, 2023).

Examination and care of the birth canal after delivery is an important part of midwifery care because perineal wounds or ruptures can increase the risk of infection if not properly cared for. Dahlan and Ansi (2023) explain that healing of perineal wounds in mothers after delivery requires proper attention and care to prevent infection. In the case of Mrs. "Y," the examination after delivery of the placenta showed no ruptures or tears in the birth canal, so no suturing was required. However, monitoring the condition of the perineum and cleanliness of the birth canal is still carried out as part of efforts to maintain maternal health in the postpartum period (Dahlan and Ansi, 2023).

The use of a gym ball also has positive effects on maternal comfort during labor. Non-pharmacological methods such as the gym ball can be used as supportive interventions in labor pain management because they are relatively safe, easy to perform, and can help improve maternal comfort (Ni'amah and Sulistiyansih, 2024).

Based on the entire care process, starting from the assessment of subjective and objective data, establishing a diagnosis, identifying potential problems, determining immediate actions, planning, implementation, and evaluation, no significant gaps were found between theory and practice. Midwifery care for Mrs. "Y" with Premature Rupture of Membranes at the Kanapa Napa Community Health Center was carried out well and the condition of the mother and fetus remained in good condition until full dilation was achieved.



Figure 1. Gym ball technique

CONCLUSION

Midwifery care for Mrs. "Y" G5P4A0, 38 weeks and 1 day of gestation with Premature Rupture of Membranes (PROM) at the Kanapa Napa Community Health Center was implemented comprehensively using Varney's 7-Step approach and SOAP documentation, starting from assessment, data interpretation, diagnosis, identification of potential problems, immediate action, planning, implementation, and evaluation. Based on the assessment results, the mother presented with complaints of clear discharge from the birth canal accompanied by contractions and abdominal pain radiating to the back. The examination results indicated that the mother and fetus were in good condition and that the membranes had ruptured. The diagnosis was made as Mrs. "Y" G5P4A0, 38 weeks and 1 day of gestation, intrauterine, singleton, live, cephalic presentation, in the first stage of labor with PROM. Care was provided through monitoring the condition of the mother and fetus, monitoring the progress of labor, meeting the mother's needs, using relaxation techniques, and using a gym ball as a complementary therapy. The evaluation results showed that the condition of the mother and fetus remained good, labor progressed progressively until full dilation, and no signs of infection or emergency were found. Thus, the objectives of the case study were achieved, and no significant gaps were found between theory and practice. Limitations of this case study include the limited observation time and the single subject, so the results of care, particularly the use of the gym ball, cannot be generalized to all women giving birth with PROM.

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