

Nursing Care To Patients With Hyperemesis Gravidarum In Duvall Building Floor Ii Of Obgyn And Obstetrics Ward At Kediri Baptist Hospital

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ABSTRACT

Background: Hyperemesis gravidarum is a excessive of nausea and vomiting that caused fluid and electrolyte imbalance. Based on data from the Medical Record Kediri Baptist Hospital during December until February 2015 there were 3 patients with hyperemesis gravidarum, nursing problem that often arise was imbalance nutrition less than the body needs. The purpose of case study to do a comprehensive nursing care.

Methods: Design of this final project was case study by comparing two respondents in obgyn and obstetrics ward at Kediri Baptist Hospital. Data were collected for 2 days by implementing a comprehensive nursing care. Nursing care is carried out starting from the assessment, diagnosis, intervention, implementation and evaluation.

Results: The result of case study assessment on respondent I found there are 3 nursing problems, and respondent II found there are 3 nursing problems based on the exist theory there are eight nursing problems. Sign and symptoms doesn't appear on both respondent. There are interventions that are not planned because of adjusting the patient's condition. Implementation there is a gap in the provision of soft diet on respondents II.

Conclusions: Conclusions on patients with hyperemesis gravidarum in nutritional imbalance problem is less than the body needs can be done independently in the form of health education on diet to pregnant women with hyperemesis gravidarum and encourage patients to add oral intake to meet the nutritional needs.

INTRODUCTION

Hyperemesis Gravidarum is vomiting nausea more than 10 times in 24 hours so that it interferes with daily work and the general state of being bad (Nurarif, 2013). Nausea and vomiting are the most common disorders in the 1st trimester pregnancy, approximately 6 weeks after the last period of 10 weeks. It is not yet known why it is certainly but suspected to be influenced by presdipositional factors such as Primigravida, Mola and double pregnancy, perhaps also organic factors such as metabolic changes and psychological factors could affect (Mitayani, 2009). There are 90% of women who experience vomiting nausea during pregnancy which can range from typical to moderate mild nausea symptoms that can heal by itself with or without vomiting to severe conditions such as Hyperemesis Gravidarum resulting in weight loss, electrolyte and metabolic disorders and long-term sequences (tyrants, 2009). Based on the results of pre-research in April 2015 that was done at the Duvall

building floor II of the obstetrics and Kediri Baptist Hospital room was found that patients with Hyperemesis Gravidarum during the last three months a number of 3 patients, experienced Hyperemesis Gravidarum level I and all experienced weight loss from weight before pregnancy. 1st trimester Pregnant women suffer from 5% weight loss with nursing problems less nutrient imbalance than body needs (Reeder, 2011).

Nausea and vomiting are described as frequent medical disorders during pregnancy. Recorded about 51.4% of women experience nausea, 9.2% of women have vomiting and about 50% of women have symptoms (tyrants, 2009). Mild nausea and vomiting between the 5th and 12th weeks is experienced 50% to 80% of pregnant women. Hyperemesis Gravidarum occurs only on an average of 1% to 2% pregnancy (Reeder, 2011). Symptoms of Hyperemesis Gravidarum occur more heavily in only 1 in 1,000 pregnancies (Mitayani, 2009).

Based on data obtained from the medical record of Kediri Baptist Hospital, from December 2014 to February 2015 of the 2,517 hospitalized patients there were 3 patients treated with a medical diagnosis of Hyperemesis Gravidarum. Nursing problems are 100% occurred in patients with medical diagnosis Hyperemesis Gravidarum in building Duvall floor II Obstetrics and gynaecology of Kediri hospital is less nutrient imbalance than body needs.

Mild nausea and vomiting are common and normal conditions in the early period of pregnancy. However, when these two things occur excessively there will be pathological impacts (Reeder, 2011).

Hyperemesis Gravidarum usually starts with morning sickness which then becomes so heavy that the patients who experience it can not eat or drink, he loses weight until dehydration. Causes of Hyperemesis Gravidarum are uncertain, with the cause of multi-factors such as the endocrine factors of increasing estrogen and progesterone hormones, psychological factors, and gastrointestinal factors (goddess, 2013) physiologically, nausea occurs due to estrogen levels increased in the blood thereby affecting the digestive system, but continuous nausea and vomiting can result in dehydration, hyponatremia, Hypochloremia, as well as decreased urine chloride which further leads to hemoconcentration which reduces blood perfusion to the tissues and causes the contamination of toxic substances. The use of deposits of carbohydrates and fats causes imperfect fat oxidation (Mitayani, 2009). This change in metabolism can lead to anaerobic that raises ketone and lactic acid. Excessive vomiting can cause changes in the electrolyte so that the blood pH becomes higher. Excessive nausea and vomiting causes the body's fluid to diminish, so that the blood becomes viscous (hemoconcentration) and blood circulation to the tissues is obstructed. If this happens then the consumption of O₂ and food to the tissue is also reduced. Lack of food and O₂ to the tissues will cause tissue damage that can affect maternal health and fetal development that it contains (Manuaba, 2008).

Management in patients with Hyperemesis Gravidarum aims to prevent significant weight loss. If weight gain is not adequate, additional nutritional therapy is essential to prevent severe protein and fat loss. Additional nutrients both are administered both enteral and parenterally, depending on the patient's condition (Reeder, 2011). Interventions that can be given to the

nursing problem of nutrient imbalance less than the body's need such as a review of mother's nutritional needs, observation of signs of deficiency of nutrients, provide food in small portions but often and warm conditions, give the food that is not fatty and oily, health education regarding the Diet Hyperemesis Gravidarum, encourage patients to eat foods that are dry and do 2009 not Nurses provide nursing care with a self-treatment of health education on the diet in pregnant women with Hyperemesis Gravidarum and encourage patients to increase oral intake to avoid significant weight loss and adequate nutritional needs.

MATERIALS AND METHODS

The study subjects in this case study consisted of two patients with hyperemesis gravidarum. Both patients who are subject to research are adult patients, namely Ny. A with the problem of nursing imbalance nutrients less than body needs, the risk of fluid and electrolyte imbalance and the risk of fetal nutritional change. Ny. P that has pain treatment problems in epigastric, less nutrient imbalance of the body's needs, and the risk of fetal nutritional changes.

Data collection is implemented 2 days. In respondents I or Ny. A was held from 18 May 2015 until 19 May 2015, in the II or Ny respondents. P is held from 29 June 2015 until 30 June 2015. The collection of research data consists of the collection of general Data (demographic Data of respondents and families) and the collection of special Data consist of assessment, nursing diagnosis, intervention, implementation and evaluation. The assessment Data includes a history of current diseases, history of past diseases, results of laboratory tests and other supporting and physical examinations. Nursing diagnosis includes the determination of the problem of nursing, etiology and symptoms (symptom). Implementing implementation Data is documented according to the implementation hours of the documentation and performed evaluation on each completed action. Patient progression Data is evaluated daily and documented in developmental records.

Interviews is a method of collecting data from primary data sources, with an interview indepth conducted to patients, nurses and families starting from the process of study, implementation up to the evaluation of nursing. As for the interviews that have been done in case studies on respondents I and II respondents with the diagnosis of nursing imbalance nutrients less than the body's need are:

RESULTS

Theme 1 Assessment

Table 1 Data Analyze

Resp	Symptomp	Problem	Etiology
1	Data Subjektif: Pasien mengatakan sering berlutuh dan sangat mengganggu disertai mual saat makan. Data Objektif: 1) Pasien menghabiskan ½ porsi makan yang diberikan. 2) Lingkar lengan atas: 25 cm 3) Berat badan sebelum hamil 45 kg, berat badan saat ini 44 kg. 4) IMT: 18,31 (kurang) 5) Mukosa bibir kering.	Ketidakseimbangan nutrisi kurang dari kebutuhan tubuh	Frekuensi mual dan muntah berlebihan
	Data Subjektif: Pasien mengatakan sering berlutuh dan sangat mengganggu disertai mual saat makan. Data Objektif: 1) Konjungtiva pucat 2) Turgor kulit turun > 2 detik 3) Bibir kering 4) Berat jenis urin > 1.030 5) N: 80x/menit 6) TD: 120/80 mmHg 7) S: 36,9°C 8) HCT: 34,9% 9) BB sebelum haml 45kg, BB saat ini 44 kg	Risiko kekurangan volume cairan	Kehilangan cairan aktif
	Data Subjektif: Pasien mengatakan sering berlutuh dan sangat mengganggu disertai mual saat makan. Data Objektif: 1) Pasien menghabiskan ½ porsi makan dari yang disediakan. 2) Berat badan sebelum hamil 45 kg, berat badan saat ini 44 kg. 3) Hb: 12,5 g/dl 4) Hct: 34,9 %	Risiko perubahan nutrisi pada fetal	Berkurangnya peredaran darah dan makanan ke fetal.
2	Data Subjetif: Pasien mengatakan nyeri ulu hati dan punggung kanan skala nyeri 5 bertambah jika habis makan. Data Objektif: 1) Pasien tampak menyeringai dan memegang perut. 2) Akral dingin 3) Nadi: 88 x/menit Mual saat makan	Nyeri pada epigastrium	iritasi gastrointestinal sekunder akibat kehamilan.
	Data Subjektif: Pasien mengatakan nyeri ulu hati dan mual saat makan sejak 2 hari yang lalu. Data Objektif: 1) Pasien menghabiskan ½ porsi makan dari yang disediakan 2) Berat badan sebelum hamil 51 kg, berat badan saat ini 46 kg 3) Lingkar lengan atas: 24 cm IMT: 19,14 (normal)	Ketidakseimbangan nutrisi kurang dari kebutuhan tubuh	Frekuensi mual muntah berlebihan.
	Data subjektif: Pasien mengatakan nyeri ulu hati dan mual saat makan. Data Objektif: 1) Pasien menghabiskan ½ porsi makan yang disediakan. 2) TFU 2 jari dibawah pusat. Hb: 11,5 g/dl	Resiko perubahan nutrisi fetal	Berkurangnya peredaran darah dan makanan ke fetal.

Theme 2 Nursing Diagnosis

Table 2 Nursing Diagnosis

Theort	Respondent I	Respondent II	Noted
Nutritional imbalances less than the body's needs: related to the frequency of excessive nausea, vomiting.	An imbalance of nutrients less than the body's needs is related to the frequency of nausea and excessive vomiting marked by patients saying they often spit and are very annoying accompanied by nausea when eating, decreased appetite. The patient consumes ½ the portion of food given, upper arm circumference: 25 cm, body weight	Nutritional imbalances less than the body's needs are related to the frequency of excessive nausea and vomiting characterized by the patient spending ½ the portion of food provided, pre-pregnancy weight 51 kg, current body	There is no gap.

Theort	Respondent I	Respondent II	Noted
	before pregnancy 45 kg, current body weight 44 kg, BMI: 18.31 (less), dry lip mucosa.	weight 46 kg, upper arm circumference: 24 cm, IMT: 19,14 (normal)	
The risk of lack of fluid volume is associated with loss of active fluid volume.	The risk of lack of fluid volume associated with loss of active fluid volume is characterized by the patient saying often spit and very annoying accompanied by nausea during meals, pale conjunctiva, skin turgor drop > 2 seconds, dry lip mucosa, urine specific gravity > 1,030, N: 80x / minute, TD: 120/80 mmHg, S: 36.9oC, HCT: 34.9%, body weight before pregnancy 45kg, current weight 44 kg	-	There is a gap between facts and theories. Both diagnoses did not appear in respondent II.
Risk of changes in fetal nutrition: associated with reduced blood circulation and food to the fetal.	The risk of changes in fetal nutrition associated with reduced blood circulation and fetal food is characterized by patients saying they often spit and are very annoying accompanied by nausea when eating. Patient consumes ½ portion of food provided, body weight before pregnancy 45 kg current body weight 44 kg, Hb: 12.5 g / dl	Risk of changes in fetal nutrition associated with reduced blood circulation and fetal food is characterized by the patient saying heartburn and nausea when eating, the patient consumes ½ portion of food provided, TFU 2 fingers below the center, Hct: 33.4%, Hb: 11.5 g / dl.	There is no gap.
Pain in the epigastrium is associated with gastrointestinal irritation secondary to pregnancy.	-	Pain in the epigastrium associated with gastrointestinal irritation secondary to pregnancy is characterized by the patient saying heartburn and right back pain scale 5 increases if after eating, the patient looks grinning and holding the stomach, acral cold, nausea when eating S: 36oC, P: 20x / minute , N: 88x / minute.	There is a gap between facts and theories. Both diagnoses did not appear in respondent I.

Theme 3 Nursing Intervention

Researchers focused interventions on respondent I and respondent II on diagnosing nutritional imbalances less than the body's needs by encouraging oral input and providing HE about hyperemesis gravidarum diet, which is expected to increase patient knowledge in order to meet the nutrients that are needed during pregnancy, other planned interventions such as: assess for food allergies, collaborate with nutritionists to determine the number of calories and nutrients the patient needs, encourage the patient to increase intake of Fe, protein and vitamin C, provide sugar substance, make sure the diet eaten is high in fiber to prevent constipation, give selected foods (has been consulted with a nutritionist), teach patients how

to make daily food records, monitor for weight loss, monitor the type and amount of activity that can be done, monitor the environment during meals, monitor dry skin and pigmentation changes, monitor skin turgor, foaming hair m, and easily broken, monitor nausea and vomiting, monitor albumin levels, total protein, Hb and hematocrit levels, monitor growth and development, monitor pale, redness, and dryness of the conjunctival tissue, monitor calories and nutrient intake. In respondent I with a diagnosis of risk of lack of fluid volume the interventions given were: maintain accurate intake and output records, monitor hydration status (adequate mucous membrane moisture, orthostatic blood pressure), if needed, monitor vital sign, monitor enter food / liquid and calculate daily calorie intake, collaborate on IV fluids, monitor

nutritional status, give IV fluids at room temperature push oral input, encourage families to help patients eat, collaborate with doctors, monitor fluid status including fluid intake and output, maintain IV lines, monitor level Hb and hematocrit, monitor vital signs, monitor patient response to fluid addition, monitor body weight, encourage patients to increase oral intake.

Theme 4 Evaluation

Evaluation results on nursing diagnoses Nutritional imbalances less than the body's needs are related to the frequency of excessive nausea and vomiting, which focuses on the independent action of providing health education about the Hyperemesis Gravidarum diet and encouraging oral input. eat, the patient eats little, BB: 44 kg, LLA: 25 cm in respondent II said that he was not nauseated, ate a little, the patient spent ½ the portion of food provided, BB: 46 kg, LLA: 23 cm.

Achievement of evaluation results in respondent II with nursing problems in epigastric pain associated with gastrointestinal irritation secondary to pregnancy, the patient said pain has not diminished, pain scale 4, no nausea, N: 88x / minute, TD: 100 / 60mmHg.

DISCUSSIONS

Theme 1 Assessment

The results of the case study obtained in the two respondents regarding nutritional status, respondent I was found nausea when eating, hypersaliva, decreased appetite, weight loss of 1 kg, only spent ½ portion of food provided. In respondent II there was heartburn, nausea when eating, weight loss of up to 5 kg, spent ½ the portion of food provided. Based on Nurarif's theory (2013), states that patients with hyperemesis gravidarum will develop symptoms such as, abdominal cramps, abdominal pain, weight loss, lack of interest in food, inability to eat food. There is a gap between theory and the fact that symptoms of abdominal pain only appear in one respondent. Epigastric pain arises due to an increase in the hormone estrogen during pregnancy which results in an increase in stomach acid, severe pain can be aggravated by the presence of injury to the epigastrium. In respondent I did not experience epigastric pain because the patient did not experience gastrointestinal irritation as evidenced by the patient spending ½ the portion of food provided with a normal dry diet, no complaints of vomiting, the patient received ranitidine injection drug therapy 2 times 1 ampoule which can reduce stomach acid.

The results of case studies obtained in both respondents regarding hydration status, respondent I obtained hypersalival patients, nausea at meals, pale conjunctiva, skin turgor decreased > 2 seconds, BAK: 6-7x / day, N: 80x / minute, S: 36, 90C. In respondent II,

there was a pale conjunctiva, good skin turgor, moist lips, BAK: 3 - 4x / day, N: 88x / minute, S: 36.90C. Based on the theory according to Nurarif (2013) states that patients with hyperemesis gravidarum will develop symptoms such as changes in mental status, decreased blood pressure, decreased pulse, decreased urine output, dry mucous membrane, dry skin, increased hematocrit, increased urine concentration, decreased body weight. There is a gap between the theory and the fact that one of the respondents who experienced some signs of symptoms of lack of fluid volume, because respondent II still got a good fluid intake as evidenced by observation for 7 hours the patient drank approximately 600 ml / 7 hours, getting RL 500 infusion cc and D5% 500 cc given alternately, good skin turgor <2 seconds, no urine examination was performed to determine the results of urine ketones.

The case study results obtained from the two respondents were seen from the activity pattern, in respondent I it was found that the patient lay in bed, personal hygiene activities such as bathing, brushing teeth, wearing clothes could be done independently. In respondent II it was found that the patient lay in bed, self-activities such as bathing, brushing teeth need help when going to the bathroom, to wear clothes can be done independently. According to Nurarif (2013), the limitation of intolerant characteristics of activity is the response of abnormal blood pressure to activity, abnormal heart frequency response to activity, discomfort after activity, expressing feeling weak. Based on these data there is a gap between the theory and the fact that the two respondents did not find the problem of intolerant activity because there were no signs of activity intolerant symptoms as the theory is evidenced by the increase in pulse frequency in respondent II is an indicator of pain response in the epigastrium not because of excessive activity. In respondent I found normal vital signs and no complaints of weakness. Based on the description, the two respondents did not experience problems intolerant of activity.

The case study results obtained by the two patients on emotional status and awareness. In both respondents showed good emotional status did not appear anxiety, GCS compositional awareness 4-5-6. According to Nurarif (2013) on the problem of the ineffective risk of brain tissue perfusion, the characteristic limits shown are abnormal partial thromboplastin periods, aortic atherosclerosis, atrial fibrillation, brain tumors, hypertension, infectious endocarditis. There is a gap between facts and theories as evidenced in the two respondents found no signs of these symptoms, consciousness of compositional patients, no examination of the heart that showed the presence of atrial fibrillation and endocarditis, the patient did not experience hypertension but hypotension. Based on the description, the two

respondents did not experience problems of ineffective risk of brain tissue perfusion.

Theme 2 Nursing Diagnosis

In the analysis of respondent I data, the diagnoses that appeared were:

- 1) Nutritional imbalance less than the body's needs is related to the frequency of excessive nausea and vomiting.
- 2) The risk of lack of fluid volume is associated with loss of active fluid volume.
- 3) The risk of changes in fetal nutrition associated with reduced blood circulation and food to the fetal.

Priority diagnosis in respondent I was: nutritional imbalance less than the body's needs related to the frequency of excessive nausea and vomiting.

In the analysis of respondent II data, the diagnoses that appeared were:

- 1) Pain in the epigastrium is associated with gastrointestinal irritation secondary to pregnancy.
- 2) An imbalance of nutrients less than the body's needs is related to the frequency of excessive nausea and vomiting.
- 3) The risk of changes in fetal nutrition associated with reduced blood circulation and food to the fetal.

Nursing diagnoses in respondent II are: Epigastric pain associated with gastrointestinal irritation secondary to pregnancy.

Based on the case study conducted, the two respondents emerged with the same two diagnoses (1) An imbalance of nutrients less than the body's needs is related to the frequency of excessive nausea and vomiting. (2) Risk of changes in fetal nutrition associated with reduced blood circulation and food to the fetal. While there are two different diagnoses from each respondent, namely (1) The risk of lack of fluid volume is related to loss of active fluid volume. (2) Pain in the epigastrium is associated with gastrointestinal irritation secondary to pregnancy.

From the existing theory, emerged eight nursing diagnoses in patients with hyperemesis gravidarum. According to Nurarif (2013) there are 5 nursing diagnoses, namely:

- 1) Nutritional imbalance less than the body's needs is related to the frequency of excessive nausea and vomiting.
- 2) Lack of fluid and electrolyte volume is associated with excess fluid loss.
- 3) Activity intolerance is related to weakness.
- 4) Risk of ineffective brain tissue perfusion.
- 5) The risk of lack of fluid volume is associated with loss of active fluid volume.

According to Mitayani (2009) there are 3 nursing diagnoses, namely:

- 1) Pain in the epigastrium associated with repetitive vomiting.

- 2) Risk of intolerance of physical activity related to weakness and lack of nutritional intake.
- 3) Risk of changes in fetal nutrition associated with reduced blood circulation and food to the fetal (fetus).

Diagnoses that appear to the respondent are in accordance with the theory although not all diagnoses according to the theory appear to the respondent. Nursing diagnosis of lack of fluid volume did not appear in the two respondents, because in respondent I there were signs of dehydration such as, skin turgor decreased > 2 seconds, dry lip mucosa, pale conjunctiva, and hypersaliva while the patient was also reluctant to drink, the patient only drank around 600 cc and BAK often. So there is a risk of lack of fluids. In respondent II, the hydration status was good, there was no sign of dehydration, the patient drank a lot, and when the assessment was not vomiting. The diagnosis of pain in the epigastrium is related to gastrointestinal irritation secondary to pregnancy appearing in respondent II because the patient complained of epigastric pain and back pain scale 5, the patient appeared to grin and hold the diseased abdomen, nausea when eating pulse 88x / minute, while in respondent I showed nausea reduced as evidenced by the patient being able to spend ½ the portion of food provided. The diagnosis of activity intolerance associated with weakness does not appear in both respondents because there are no signs of weakness which means that the patient is able to sit, wake up and walk to the bathroom by himself. Diagnosis The risk of ineffectiveness of brain tissue perfusion does not appear in both respondents because there are no signs that indicate the ineffectiveness of brain tissue perfusion is evidenced by the patient not experiencing hypertension but hypotension, not doing cardiac examination of the heart, the patient's emotional status is good and the status of consciousness is good, GCS 4- 5-6. Based on the description it was found that the diagnoses in hyperemesis gravidarum patients that did not appear in the two respondents there were 4 diagnoses, the same diagnosis in the two respondents there were 2 diagnoses and 2 different diagnoses.

Theme 3 Nursing Intervention

According to Nurarif (2013) interventions in diagnosing nutritional imbalances less than the body's needs, namely: assessing food allergies, collaborating with nutritionists to determine the number of calories and nutrients the patient needs, encourage patients to increase their intake of Fe, protein and vitamin C, give the substance of sugar, make sure the diet you eat contains high fiber to prevent constipation, give selected foods (have consulted with a nutritionist), teach patients how to make daily food records, monitor for weight loss, monitor the type and amount of activity that can be done, monitor the environment during eat, schedule treatments and actions not during

meal hours, monitor dry skin and pigmentation changes, monitor skin turgor, dull and easily broken hair, monitor nausea and vomiting, monitor albumin levels, total protein, hemoglobin and hematocrit levels, monitor growth and development, monitors pale, reddish, and conjunctions of tissue dryness, monitor calories and nutrition intakes. Based on the description there is a gap between theory and facts. Researchers found planned interventions that are not appropriate to the theory because it adjusts to the patient's condition, namely: schedule treatment and actions not during meal hours, this is not planned because the time of drug administration is pre-arranged and has been scheduled according to doctor's advice. Note the presence of edema, hyperemic, hypertonic, papillae of the tongue and oral cavity, note that if the tongue is magenta, scarled, this intervention is not planned because it is not according to the patient's condition at the time of assessment.

According to Nurarif (2013) on the diagnosis of the risk of lack of fluid volume, namely: Weigh diapers / pads if needed, maintain accurate intake and output records, monitor hydration status (adequate moisture mucous membrane moisture, orthostatic blood pressure), if needed, monitor vital signs, monitor enter food / fluid and calculate daily calorie intake, collaborate on IV fluids, monitor nutritional status, give IV fluids at room temperature, encourage oral input, give nasogastric replacements according to output, encourage families to help patients eat, collaborate with doctors, manage possibilities transfusion, preparation for transfusion, monitor fluid status including fluid intake and output, maintain IV lines, monitor hemoglobin and hematocrit levels, monitor vital signs, monitor patient response to fluid addition, monitor body weight, encourage patients to increase oral intake, administering IV fluids monitor for signs and symptoms of excess fluid volume, monitor for signs of kidney failure. Based on the description there is a gap between theory and facts. Unplanned interventions in respondent I, namely: weigh diapers / pads if needed, this was not planned because the patient did not experience vaginal discharge and could urinate spontaneously so as not to use diapers / pads. Give a nasogastric replacement according to the output, this is not planned because the patient does not use nasogastric. Set the possibility of transfusion, preparation for transfusion, this was not planned because the hemoglobin value in respondent II was 11.5 g / dl in the normal range of 11.4 - 15.1 g / dl. Provision of IV fluids monitor for signs and symptoms of excess fluid volume, monitor for signs of kidney failure, the intervention is not planned because it does not suit the circumstances and needs of the patient. Patients had no signs of excess fluid volume because they were found during the study, namely: dry lip mucosa, pale conjunctiva, decreased skin turgor, BAK 6-7x / day, HCT 34.9%,

these were some of the signs and symptoms of nursing problems risk of lack of fluid volume.

Nursing implementation carried out in patients with hyperemesis gravidarum for nursing problems nutritional imbalance is less than the body's needs, namely the provision of independent action by providing health education about the hyperemesis gravidarum diet and encouraging to increase oral intake. In respondent II health education about hyperemesis gravidarum diet adjusted to the state of patients who also experience gastritis, on hyperemesis gravidarum diet patients should be given dry food, but patients with gastritis are encouraged to eat soft foods, based on the results of case studies there is a gap between theory and fact. When given the implementation of the hyperemesis gravidarum diet on the first day the patient is maximized because the patient already understands the importance of nutrients needed during pregnancy according to the hyperemesis gravidarum diet can meet oral input as evidenced from subjective data the patient says he already understands the principles and types of diet hyperemesis gravidarum objective data, the patient mentions the principle hyperemesis gravidarum and the effects of hyperemesis gravidarum hyperemesis gravidarum, various hyperemesis gravidarum diets. On the second day HE was still given to see how the patient's understanding of hyperemesis gravidarum and the patient is expected to be able to perform nutritional fulfillment orally. Respondents I and Respondents II for all nursing problems in providing implementation for two days were adjusted to the patient's condition at the time of data collection.

Theme 4 Evaluation

Evaluation according to Nurarif (2013) During 2x24 hours the patient is able to report an adequate daily intake and daily weight has been stable with the results criteria, an increase in body weight according to purpose, ideal body weight according to height, able to identify nutritional needs, there is no sign of a sign of malnutrition, indicating an increase in the taste function of swallowing, no significant weight loss. The results of the case study evaluations on respondents I and II were found to be able to identify nutritional needs as evidenced by the patient being able to mention the principles and types of the Hyperemesis Gravidarum diet, already willing to eat, the patient is able to spend portions of food by eating small amounts but often.

Evaluation analysis according to Nurarif (2013) During 2x24 hours the patient is able to report an adequate daily intake and daily weight has been stable with the results criteria, there is an increase in body weight according to purpose, ideal body weight according to height, able to identify nutritional needs, there is no sign - signs of malnutrition, showing increased taste function from swallowing, no significant weight loss. The results of the case study evaluations on respondents I and II were found to be able to identify

nutritional needs as evidenced by the patient being able to mention the principles and types of the Hyperemesis Gravidarum diet, already willing to eat, the patient was able to spend portions of food by eating small amounts but often. respondents' evaluation of the outcome criteria of Nurarif's theory (2013) was that patients reported that pain was reduced by using pain management. The results of the case study on respondent II obtained during 2 days of treatment found that the problem was resolved in part as evidenced by the patient saying pain was reduced by the pain scale 4, seemed to grin pain and hold the sick stomach.

Achievement of the evaluation results on respondents I with nursing problems the risk of lack of fluid volume obtained by the patient said that he was not nauseated, moist lip mucosa, TD: 110/60 mmHg, S: 36.2oC. Analysis of respondents' evaluation of the outcome criteria of Nurarif's theory (2013) maintaining urine output according to age and weight, normal urine density, normal hematocrit, normal blood pressure, pulse, body temperature within normal limits, no signs of dehydration, elasticity good skin turgor, moist mucous membrane, no excessive thirst. The results of the case study on respondent I obtained during 2 days of treatment found that the problem did not become actual because there were no signs of inhalation evidenced by the patient wanting to eat up 1 portion of food provided, the patient ate little but often, moist mucous membrane, already do not get parenteral nutrition.

The results of the evaluation of nursing diagnoses the risk of changes in fetal nutrition obtained patients can eat a little, there is no problem of lack of fluid and electrolyte volume, the conclusion of the ultrasound examination is a single intrauterine pregnancy, good DJJ, based on the theory according to Mitayani (2009) objectives on nursing diagnoses the risk of changes in fetal nutrition is 2x24 hours of uninterrupted fetal development. so the results of case studies on respondents I and II show that the risk of changes in fetal nutrition does not become actual proven by TFU according to gestational age, which indicates that the fetus is developing well and getting good nutrition, the mother spends ½ the portion of food provided, and FHR is good.

CONCLUSIONS

The results of the case study on the assessment of respondent I and respondent II with Hyperemesis Gravidarum there is a gap between theory and facts. In respondent I three nursing problems emerged. In respondent II three nursing problems emerged. The diagnoses found in each respondent appear in 2 different diagnoses, namely the risk of lack of fluid volume and epigastric pain. Diagnosis There is a gap between the theory and the facts that appear on both respondents.

The interventions given to respondents I and II as a whole are in accordance with existing theories. Implementation carried out on respondents I and respondent II can be carried out properly in accordance with the interventions that have been formulated. Evaluation of the two respondents conducted at the end of the nursing process, especially on HE self-measures regarding the hyperemesis gravidarum diet and encouraging oral input given for 2 days can help increase knowledge and increase oral input.

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