

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Andrea Egert-Perez

Date: 1-23-2025

DAS Assignment # 1

Name of the defendant: Oliver Daleno Bravo

License number of the defendant: 874193

Date action was taken against the license: July 2, 2020

Type of action taken against the license: Probated Suspension

- *Use the space below to describe the events which led to the action(s) taken against the license. If multiple charges were in play, be sure and cite them, e.g. drug diversion, HIPAA violation, abandonment, forfeiture on student loans, etc.*

Mr. Bravo had three discrepancies that led to legal actions taken against him resulting to Mr. Bravo receiving probated suspension. All three violations were at different time while being employed at University Health System in San Antonio.

The first violation the nurse had a patient who was complaining of pain. The nurse documented that he administered Tylenol for pain purposes although there was no record showing the medication was dispensed by the EMAR system. Also, the nurse failed to document the pain location and dose at which the medication was given. It is unclear because of the poor documentation if the patient ever ended up receiving pain medication. This could also have been an issue for further treatment if it is unclear of what the patient has received and when.

The second violation happened a year prior to the first violation. The nurse had a patient that had an elevated blood pressure. The nurse recorded vitals numerous times in a 12-hour period but failed to intervene and provide care for the patient. Towards the end of the shift the nurse notified the physician and informed of the elevated blood pressure. The physician gave orders to administer the hypertensive medication and he never ended up giving it. The on coming nurse noted the patient to be unresponsive. The patient was evaluated by a physician and determined the patient suffered an intracerebral bleed and died the next day.

The third offense happened approximately 7 months later. The nurse had a patient who complained of a headache. The nurse then noted the patient had an elevated blood pressure and waited approximately two hours to administer the anti-hypertensive medication the physician order. The nurse stated the patient never complained of any pain and that the doctor was aware of the elevated blood pressure. The nurse stated he tried numerous times to call the doctor with no success, so he used his own personal phone to reach the physician. The nurse reported after he gave the anti-hypertensive medication, the patient's blood pressure decreased, and no neurological symptoms were present. The nurse then reported he assessed the patient 25 minutes later and the patient had developed slurred speech. The nurse reported he tried to contact the physician again but with no success, so he

contacted another physician that informed him to call a code stroke. In patient report, the code stroke was not called until approximately two hours after the symptoms occurred and by the time the patient was scanned via CT machine, she had suffered a hemorrhagic stroke affecting the brain stem. This patient subsequently died.

- Use the space below to provide a description of measures you think could have prevented any action being taken against the license and/or would have prevented harm to the patient, if harm occurred.

The nurse could have prevented this in many ways. There were many steps in the process that were missed along the way. Basically, one mistake piled into many. In the first situation, he did not follow the seven medical administration rights and did not withdraw the medication properly or document the right dosage. This happened not only once, but twice. The second situation he delayed contacting a physician about an increasing blood pressure and then once he did, still did not give the medication right away. He delayed the treatment of the elevated blood pressure that ending up resulting in a brain hemorrhage and death. This could have been prevented by being proactive and an advocate for his patient. Also, properly reassessing his patient could have led to the discovery of the stroke symptoms much quicker. The third situation is very similar to the second. This, to me, shows negligence, because this just occurred seven months prior and nothing changed about his care. After the first patient died from the result of his nursing care, he still refused to improve or learn from it. This is why I believe he was ultimately brought up to the nursing board and received punishment and suspension.

Identify ALL universal competencies were violated and explain how.

The universal competencies that Mr. Bravo violated were safety and security (physical and emotional), critical thinking, documentation, human caring.

Safety and security (physical and emotional):

The nurse violated the physical and emotional safety and security competencies. In the physical section, the nurse violated the 7 rights of medication and administration by not giving the antihypertensive medication on time after the physician ordered it. The first patient he reported he gave the medication but never withdrew the medication. This violates the physical because the patient never received proper pain relief. The emotional was not met either because the nurse did not provide the 4 P's. He did not address the pain and therefore the patient was hurting much longer than was necessary. I would also go to say that trust and respect was not given to any of the three patients that he cared for.

Critical Thinking:

In the critical thinking category, the nurse violated decision making, prioritization task/procedures, evaluation and revision of interventions, and assessment related to patient symptoms. The nurse did not assess the patient appropriately. When the patient started to show signs and symptoms of a stroke, the nurse did not prioritize the time and intervene with proper interventions. His decision-making skills were ultimately the reason two patients passed away.

Documentation:

The nurse falsified on the documentation with his first patient. He reported giving the medication, but did not document it properly. He also never scanned the medication in the EMAR system, which would

have prevented further mistakes in documentation of the dose and time. He also did not properly document and assess two critical hypertensive patients. This led to worsening symptoms and untimely interventions.

Human Caring:

The nurse did not listen to the patient's needs and therefore violated the human caring competency. He documented pain, however, did not address the issue. The nurse reported he administered Tylenol for pain, however, because his documentation was poor it is unsure if the the medication was administered to the patient at all.

- *Use the space below to describe what action you think a prudent nurse would take as the first to person to discover the event described. In other words, you are the one who discovers the patient has been harmed by the nurse or you have discovered the impairment or criminal activity cited in the disciplinary action.*

If I was the nurse that discovered the events that have taken place, then I would first check on the patient and perform a focused assessment. I would then assess the patient's vitals to make sure they are stable. After assuring the patient's safety, then I would start up the chain of command to report the incident. I would inform the charge nurse and email the nurse manager so that the incident could be further investigated. I would also call the physician and inform him of the situation so that proper treatment and care could be given to the patient.