

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Cameron Cloud

Date: 4/4/2025

DAS Assignment # 1

Name of the defendant: Oliver Daleno Bravo

License number of the defendant: 874193

Date(s) and BON decision(s) taken against the license:

Probated suspension 5/21/2021

Type of action(s) imposed to retain or regain licensure, if applicable (ex.: warning with stipulations, etc.)

Must comply with all respects with the Nursing Practice Act, Texas Occupations Code 301.001 et seq., the rules and regulations relating to nursing education, licensure, and practice, 22 Tex. Admin code 221.1 et seq

Within 30 days has to complete Boards online courses and remedial education courses within 1 year. He must work in the state of Texas providing direct patient care for a minimum of 64 hours per month for 2 years. Must notify present and future employers of the orders given and each employer must submit notification of employment form within 10 days of receipt of the order. Must have direct supervision for 4 quarters and remainder of the quarters and the other 4 can be indirect supervision. Must have an evaluation done by all future employers every 3 quarters of the 8 required.

- *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 each of them, e.g. drug diversion, HIPAA violation, abandonment, etc.*

Oliver Bravo had multiple violations documentation errors and delayed interventions while in the clinical setting leading to these disciplinary actions. These included: documenting that Tylenol was given but didn't document the pain assessment or location of pain, also Tylenol was not taken out of the medication dispensing system, did not intervene for elevated blood pressure and received an order for anti hypertensives but did not administer the medication, did not intervene for a headache and elevated blood pressure for 2 hrs leading to death.

The RN documented that he gave Tylenol but did not specify a dose or route. He also didn't document the pain assessment or location of the pain. Also, there is no indication that Tylenol was removed from the medication dispensing system for this patient. This can injure the patient and cause other health caregivers to be confused with prior care given.

Oliver also failed to intervene with another patient who had extremely elevated blood pressures for 9 hours. The RN received orders for anti-hypertensives but did not administer them to the patient. This patient ended up having a intracerebral hemorrhage and succumbed to the injuries.

The RN left a patient with high blood pressure for 2 hours before intervention. Medication was given but the patient started to present with slurred speech and weakness. He eventually called a code stroke but the patient already had a hemorrhagic brain stem.

- *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.*

This RN should have accurately documented all assessments and interventions. He shouldn't have documented that he administered a medication that was not given. Also, with both patients that had elevated blood pressures he should have intervened very quickly and followed all physicians orders that are given. He should have prioritized medication administration and protocols.

- *Identify ALL universal competencies (4-5) that were violated and explain how in detail to reflect your understanding and importance of the universal competencies.*

Competencies that were violated were safety and security, critical thinking, documentation, and human caring.

Safety and security was violated when the RN didn't accurately document a pain assessment and stated that the patient received Tylenol when they didn't. This also violated the 7 rights of med admin. This RN also didn't administer an anti-hypertensive medication that they had orders for and left a patient with extremely high blood pressure for 9 hours.

Critical thinking was violated by the RN they didn't use good decision making when allowing 2 patients to have high blood pressure without any interventions. This led to both patients having a stroke that eventually led to their death.

Documentation was violated because this RN did not give Tylenol like they said they did and also didn't document any assessment prior to giving this medication. This behavior will lead to other caregivers not having the correct information for future interventions and assessments.

Human caring was violated by not listening to the patients concerns when they told the RN they had a headache and an elevated blood pressure. This led to the patient having a hemorrhagic brain stem and later led to death.

- *Use the space below to describe what actions 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.*

With patient A, I would assess the patient for pain and if they have good cognitive ability ask if they received Tylenol by the prior nurse. Then I would talk to Oliver and ask him if he administered the medication and if so why it was not pulled from the medication dispensing system. I would provide education to him about correct documentation and report the situation to the charge nurse or someone in charge.

With Patient B, Since the patient could not be woken up and had a BP of 214/103, I would immediately notify a physician and call for help. Then I would notify the charge nurse and physicians that the anti-hypertensives were not administered over the 9 hours that the patient presented with high BP and report the RN to the state board.

For Patient C, I would have immediately checked the patients BP again and would have called a code stroke so the rapid response team could come assess the patient who had slurred speech and weakness. Then I would have verified how long the patient was in this state and reported the information to the charge nurse and physicians. Then I would turn the nurse into the state board because the patient did not receive proper interventions.