BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 599400	§	
issued to BRIDGET WEYINMI REWANE	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Boar produced evidence indicating that BRIDGET WEYINMI REWANE, Registered Nurse License Number 599400, hereinafter referred to as Respondent, may have violated Section 301.452 (b)(10)&(13), Texas Occupations Code.

An informal conference was held on February 7, 2012, at the office of the Texas Board of Nursing, in accordance with Section 301.464, Texas Occupations Code.

Respondent appeared in person. Respondent was represented by Nancy Roper Willson, Attorney at Law. In attendance were Mary Beth Thomas, PhD, RN, Director of Nursing, Executive Director's Designee; Lance Brenton, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Amy Grissom, RN, Investigator.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and consented to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from School of Nursing, University College Hospital, Ibadan, Nigeria, on August 1, 1983. Respondent was licensed to practice professional nursing in the State of Texas on December 23, 1993.

5. Respondent's nursing employment history includes:

1983-1989		Unknown
10/1990-10/1993	Staff Nurse	Harlem Hospital New York City, New York
11/1993-3/1994		Unknown
4/1994-4/1996	Staff Nurse Maternity	Abilene Regional Medical Center Abilene, Texas
5/1996-7/1997		Unknown
8/1996-10/1996	Staff Nurse	Arlington Memorial Hospital Arlington, Texas
11/1996-2/2000		Staff Nurse Kindred Rehabilitation Hospital Arlington, Texas
2/2000-9/2001	Staff Nurse	Charlton Methodist Hospital Dallas, Texas
10/2001-1/2002		Unknown
2/2002-6/2004	Staff Nurse Outpatient Surgery	Osteopathic Hospital of Texas Fort Worth, Texas
6/2004-3/2007	Charge Nurse	Health South Rehabilitation Hospital Arlington, Texas
3/2007-12/2010	Staff Nurse	Lifecare Hospital of Dallas Dallas, Texas
01/2011 - 2/2010		Unknown
03/2010-Present	Staff Nurse	Healthsouth Rehabilitation Hospital Arlington, Texas

6. At the time of the incident, Respondent was employed as a Staff Nurse with Lifecare Hospital of Dallas, Dallas, Texas, and had been in this position for three (3) years and eight (8) months.

7. On or about November 26, 2010, while employed with Life Care Hospital of Dallas, Dallas, Texas, Respondent failed to assess Patient Number 607796, when the patient was unexpectedly transferred to Life Care Hospital from another facility. Respondent accepted the patient from the Emergency transport team after the Emergency Medical Technicians (EMT) transferred the patient into a patient room. While settling the patient into the room the EMT's failed to attach the patient's nasal cannula to the oxygen flow meter on the wall in the patient's room. Respondent failed to request a patient report from the EMT's prior to their departure from the hospital and so did not know that the patient had been on oxygen at the former facility and during transport. Respondent interviewed the patient in her bed but failed to notice that the patient had a nasal cannula that wasn't attached to oxygen. After receiving a copy of the patient's vital signs from the Nurse Assistant and documenting them in the patient's medical record, Respondent failed to follow up with the abnormal readings by completing a nursing assessment of the patient. Consequently, the patient suffered respiratory distress, coded, and required cardiopulmonary resuscitation. The patient, who had been transferred to Life Care Hospital for end of life care, later died. Respondent's conduct exposed the patient unnecessarily to risk of harm from ineffective treatment which may have contributed to the patient's demise.

8. In response to Finding of Fact Number Seven (7), Respondent states that she signed the EMS note and went to see the Patient. Respondent states that the patient was awake and quiet in bed, she looked weak and lethargic with flushed skin. Respondent states that the patient was on room air and Respondent noted no shortness of breath or other signs of respiratory distress. Respondent states that the room was not set up for oxygen by a respiratory therapist. Respondent states that the patient arrived without any pre-admission paperwork and without report from the transferring facility. Respondent states that a nurse tech took the patient's vital signs and gave them to her written on a piece of paper. Respondent states that the vital signs were stable and that the nurse tech expressed no concerns as to the patient's breathing or any other problems. Respondent states that the usual practice is for the transferring hospital to call in report to the receiving hospital, but that had not done this time. Respondent states that the patient had been transferred unannounced. Respondent states that the patient's condition must have changed quickly because about fifteen (15) minutes after she left the patient's room, and while she was with one of her other five patients, she heard a Code Blue called for the patient's room. Respondent states that she quickly responded and actively participated in the resuscitation of this patient.

9. On September 29, 2011, Respondent successfully completed a course in Texas nursing Jurisprudence and Ethics, entitled "Protecting Your Patients and Your Practice" which would have been a requirement in this Order.

10. On December 12, 2011, Respondent successfully completed a course in Sharpening Critical Thinking Skills, which would have been a requirement in this Order.

11. On February 3, 2012, Respondent successfully completed a physical assessment course, which would have been a requirement in this Order.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(B),(1)(D),(1)(M)&(3)(A) and 217.12(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 599400, heretofore issued to BRIDGET WEYINMI REWANE, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that when this Order becomes final and the terms of this Order become effective, a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 06th day of April, 2012.

BWR
BRIDGET WEYINMI REWANE, RESPONDENT

Sworn to and subscribed before me this 06 day of April, 2012.

SEAL

SONYA RENEE DAVIS
My Commission Expires
November 7, 2015

Notary Public in and for the State of Texas

Approved as to form and substance.

Nancy Roper Willson, Attorney for Respondent

Signed this 12th day of April, 2012.

599400:147

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WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 6th day of April, 2012, by BRIDGET WEYINMI REWANE, Registered Nurse License Number 599400, and said Order is final.

Effective this 12th day of April, 2012.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board