BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED ORDER
Registered Nurse License Number 874193	§	
issued to OLIVER DALENO BRAVO	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of OLIVER DALENO BRAVO, Registered Nurse License Number 874193, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on July 2, 2020.

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 agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received an Associate Degree in Nursing from San Antonio College, San Antonio, Texas, on May 13, 2013. Respondent was licensed to practice professional nursing in the State of Texas on March 3, 2015.

5. Respondent's nursing employment history includes:

5/2015 - Unknown	Registered Nurse	Methodist Hospital San Antonio, Texas

Respondent's nursing employment history continued:

4/2018 – 2/2020	Registered Nurse	University Health System San Antonio, Texas
3/2020 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with University Health System, San Antonio, Texas, and had been in that position for three (3) months.

7. On or about July 20, 2018, while employed as a Registered Nurse with University Health System, San Antonio, Texas, Respondent failed to accurately and completely document the pain assessment for Patient MRN 21973285 in that Respondent failed to document the location of the patient's pain. In addition, Respondent documented the administration of scheduled Tylenol for the aforementioned patient at 10:00 and 16:00 when there is no record of Respondent removing Tylenol from the medication dispensing system for the patient. Respondent also failed to accurately and completely document the dose of the Tylenol administered. Respondent's conduct resulted in an incomplete medical record, and was likely to injure the patient in that subsequent caregivers did not have accurate and complete information on which to base their decisions for further care.

8. On or about June 20, 2019, while employed as a Registered Nurse with University Health System, San Antonio, Texas, Respondent failed to timely escalate and/or intervene for the elevated blood pressures for Patient MRN 00841700, which were documented as 178/104 at 09:32, 185/103 at 14:58, and 197/106 at 18:50. At 18:55, Respondent paged the physician and received an order for anti-hypertensive medication, but failed to administer the medication to the patient. Subsequently, at 19:30, the nurse on the following shift found the patient unarousable with a blood pressure of 214/103 and notified the physician. Patient MRN 00841700 was found to have an intracerebral hemorrhage and expired the following day. Respondent's conduct may have contributed to the patient's demise.

9. On or about January 29, 2020, while employed as a Registered Nurse with University Health System, San Antonio, Texas, Respondent failed to timely intervene at approximately 07:40 when Patient MRN 00921002 reported a headache and Respondent received notice that her blood pressure was elevated at 190/66. Instead, Respondent waited until 09:23 to begin administering medications, including anti-hypertensive medication, to the patient. Thereafter, Respondent failed to timely intervene by immediately calling for a Code Stroke when he rechecked the aforementioned patient's blood pressure at 09:50, which was documented as 170/60, and documented the patient's slurred speech and weakness at 09:55. Instead, Respondent spoke to another physician to assess the patient, the other physician contacted the patient's physician, who ordered Respondent to call a Code Stroke, which he did at 10:13. Subsequently, Patient MRN 00921002 received a computed tomography (CT) scan at 10:58, which showed a hemorrhagic brain stem. Patient

MRN 00921002 was transferred to the Intensive Care Unit and expired later that evening. Respondent's conduct may have contributed to the patient's demise.

10. In response to the incident in Finding of Fact Number Seven (7), Respondent states that he rounded on all of his patients that day and asked if any of his patients were in severe pain. Respondent states that none of his patients reported pain at the time that he rounded. Respondent states that all assessments were recorded and charted. In response to the incident in Finding of Fact Number Eight (8), Respondent states that the doctors were aware of the elevated blood pressure when they rounded. Respondent states that the patient showed no neurological death throughout the day, and was able to walk and talk. Respondent states that towards the end of his shift, the patient left for a CT scan, and arrived back at shift change. In response to the incident in Finding of Fact Number Nine (9), Respondent states that he attempted to contact both physicians through the messaging system and then used his own cell phone to notify the doctors of the elevated blood pressure. Respondent states that other than the elevated blood pressure, the patient was asymptomatic and had a history of high blood pressure, which was alleviated with medication. Respondent states that he gave the patient her medications at approximately 9:24, her blood pressure went down, and the patient was stable. Respondent states that at 9:50, the patient began slurring her speech. As he had not been able to reach the two physicians, he asked another physician, who was rounding, to come check on the patient. The physician was able to contact the patient's physician on her cell phone. Respondent states he spoke to the physician who advised calling a Code Stroke, which he immediately did.

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 violation(s) of 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C),(1)(D),(1)(M),(1)(P)&(3)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 874193, heretofore issued to OLIVER DALENO BRAVO.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that Registered Nurse License Number 874193, previously issued to OLIVER DALENO BRAVO, to practice nursing in the State of Texas is/are hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this Order.

A. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

B. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to comply in 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 §§211.1 *et seq.*, and this Agreed Order.

III. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: *http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp*. Upon successful

completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

IV. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not be approved.

B. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

C. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. Home study courses and video programs will not be approved.

D. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers:** RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. **Indirect Supervision:** For the remainder of the stipulation/probation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

E. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

VI. FURTHER COMPLAINTS

If, during the period of probation, an additional allegation, accusation, or petition is reported or filed against RESPONDENT'S license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

VII. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may 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 Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this 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 this Order is subject to ratification by the Texas Board of Nursing and a copy of this Order will be mailed to me once the Order becomes effective. 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 possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 21st day of May, 2021.

OLIVER DALENO BRAVO, RESPONDENT

Sworn to and subscribed before me this _____ day of _____, 20____.

SEAL

_____

Notary Public in and for the State of _____

Approved as to form and substance.

Alejandro Mora, Attorney for Respondent

Signed this 21 day of May, 2021.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 21st day of May, 2021, by OLIVER DALENO BRAVO, Registered Nurse License Number 874193, and said Agreed Order is final.

Effective this 8th day of June, 2021.

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