BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED ORDER
Registered Nurse License Number 605004	§	
& Vocational Nurse License Number 145206	§	
issued to CHRISTINA DIANE REDDEN	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of CHRISTINA DIANE REDDEN, Registered Nurse License Number 605004, and Vocational Nurse License Number 145206, 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.

An informal conference was conducted on October 6, 2020, in accordance with Section 301.464, Texas Occupations Code. Respondent appeared by telephone. Respondent was represented by Giana Ortiz, Attorney at Law.

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

4. Respondent received a Certificate in Vocational Nursing from Texas Special, Texas, on May 1, 1993. Respondent received a Baccalaureate Degree in Nursing from Dallas Baptist College, Dallas, Texas, on May 25, 1994. Respondent was licensed to practice vocational nursing in the State of Texas on December 1, 1993. Respondent was licensed to practice professional nursing in the State of Texas on June 22, 1994.

5. Respondent's nursing employment history includes:

12/1993 – 3/1994	Licensed Vocational Nurse	Methodist Medical Center Dallas, Texas
4/1994-6/1994	Unknown	
7/1994-5/1999	Registered Nurse	Bethel Home Care Duncanville, Texas
5/1999-11/2000	Registered Nurse	Parkland Health & Hospital System Dallas, Texas
11/2000-3/2003	Registered Nurse	Las Colinas Medical Center Irving, Texas
10/2001-4/2003	Registered Nurse	North Hills Hospital North Richland Hills, Texas
4/2003-7/2005	Registered Nurse	Kindred Hospital Dallas, Texas
1/2005-4/2006	Registered Nurse	NurseCore Fort Worth, Texas
7/2005-1/2006	Registered Nurse	TriTrax Home Care Arlington, Texas
4/2008-6/2009	Registered Nurse	Ameritex Arlington, Texas
6/2009-5/2020	Registered Nurse	First Call of Dallas Dallas, Texas
1/2015-1/2020	Registered Nurse	Eagle Mountain Saginaw Independent School District Saginaw, Texas
5/2020-10/2020	Registered Nurse	ATC HealthCare Dallas, Texas
10/2020-Present	Registered Nurse	Total Care Emergency Room Benbrook, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District, Saginaw, Texas, and had been in that position for three (3) years and eight (8) months.

7. On or about August 19, 2019, through November 5, 2019, while employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District (EMSISD), Fort Worth, Texas, and assigned to Saginaw High School, Saginaw, Texas, Respondent failed to document multiple medication administrations for medications that Respondent administered to seventeen (17) students. Respondent's conduct resulted in incomplete medical records and was likely to injure the patients from subsequent care decisions made without the benefit of accurate and reliable information.

8. On or about August 2019 through October 2019, while employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District (EMSISD), Fort Worth, Texas, and assigned to Saginaw High School, Saginaw, Texas, Respondent failed to ensure to that the automatic external defibrillator (AED) pads and batteries had not expired. Additionally, Respondent failed to check AED and ensure that monthly check reports were completed after she delegated the task to the nursing assistant. Subsequently, several of the AED pads and batteries had expired and the required monthly checks had not been completed. Respondent's conduct exposed patients to a risk of harm from unavailability of appropriate emergency medical supplies.

9. On or about November 4, 2019, while employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District (EMSISD), Fort Worth, Texas, and assigned to Saginaw High School, Saginaw, Texas, Respondent failed to adequately assess and/or document her assessment of Student KW, including failure to document a full set of vital signs or neurological assessment at the time of the incident. The student exhibited signs of seizure activity and failed to respond to verbal or sternal rub stimuli. Subsequently, staff performed an impairment assessment after a vape pen was found on the student, and she was sent home with her parents. Respondent's conduct resulted in an inaccurate medical record and was likely to injure the patient in that subsequent care givers would not have accurate and complete information on which to base their care decisions.

10. On or about November 5, 2019, through November 6, 2019, while employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District (EMSISD), Fort Worth, Texas, and assigned to Saginaw High School, Saginaw, Texas, Respondent failed to ensure and obtain parent authorization consents for twenty-two (22) student medications prior to entering information into electronic medical record (EMR). Respondent's conduct unnecessarily exposed the patients to risk of harm from administration of a medication without parent's consent.

11. On or about November 5, 2019, through November 6, 2019, while employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District (EMSISD), Fort Worth, Texas, and assigned to Saginaw High School, Saginaw, Texas, Respondent failed to obtained the signed physician order for Nasal Versed for Student E.L.

Respondent's conduct unnecessarily exposed the patient to risk of harm from administration of a medication without physician's orders.

12. On or about November 5, 2019, through November 6, 2019, while employed as a Registered Nurse with Eagle Mountain Saginaw Independent School District (EMSISD), Fort Worth, Texas, and assigned to Saginaw High School, Saginaw, Texas, Respondent failed to obtain parent authorization for Diastat for Student B.M. Respondent's conduct unnecessarily exposed the patient to risk of harm from administration of a medication without parent's consent.

13. In response to the incident in Finding of Fact Number Seven (7), Respondent states that both the nurse and the medical assistant in the high school clinics gave medications. Respondent states that she can only document the medications that she gave. Respondent states that there are times when a student misses' doses of medications for various reasons. Respondent states that she would go back and run reports and research any doses of medications that showed up on the report and mark them appropriately. Respondent states that she was using lots of substitutes during this time, so this may be the cause of so many doses being on the missed dose report. In response to the incident in Finding of Fact Number Eight (8), Respondent states that the job of checking the automatic external defibrillator (AED) was assigned to the medical assistant (MA), and when asked, the MA had assured Respondent that the monthly checks were done. Respondent states that the new pads had just been delivered for four of the machines as the other four machines had just been bought the previous year and were less than a year old and not needing replacement pads yet. Respondent states that this was a simple error and did not endanger the safety of any students. In response to the incident in Finding of Fact Number Nine (9), Respondent states that on the morning of the incident, the student was already in the clinic with a friend. Respondent states that a few minutes after hanging up the phone with the patient's mother, she noticed that the student was sitting on the floor, had her eyes closed, and was shaking her hands in what looked like an imitation of a seizure. Respondent states that she assessed the student and she was resisting her attempts to open her eyelids by squeezing them harder shut. Respondent states that she pulled lightly on her hands and she resisted that as well. Respondent states that that MA and herself placed themselves at the side of KW and were able to easily lift her to standing as she assisted them and dropped her legs and feet and walked to the clinic bed. Respondent states that they laid her at the foot of the bed and as they were moving her up into the bed, in a better position, the vape pen and her cell phone fell out of her pockets. Respondent states that she stayed at the bedside and the MA retrieved Respondent's blood pressure cuff, thermometer, stethoscope, and pulse ox so that Respondent could take vital signs. Respondent states that the athletic trainer performed the sternal rub and the student opened her eyes and responded. Respondent states that at no time was the student in distress that needed 911 services. In response to the incident in Finding of Fact Number Ten (10), Respondent states that for all students that had a medication entered into the computer, they first had a consent form completed and signed by a parent or legal guardian. Respondent states that the process was that the form be brought in with the medication. Respondent states she would verify that the medication listed matched the medication that was brought in, then she would enter it into the student's

profile. Respondent states that then she would give it to the MA assistant, who would verify that she had entered it correctly, print out two pictures of the student, one picture was placed on the box where the medication was stored, and one was stapled to the form and then the form was filed in the red medication notebook. Respondent states that after the MA quit her job, she found piles of paperwork with these forms, as well as care plans, vaccination records, and such shoved into desk drawers. Respondent states that she was not aware that they had not been filed away in the red book. In response to the incident in Finding of Fact Number Eleven (11), Respondent states that the student did have an assigned health plan for his seizures. Respondent states that the nasal versed was in the clinic and was entered into the emergency contact section of the student's record so that anybody who pulled up the student had access to that information. In response to the incident in Finding of Fact Number Twelve (12), Respondent states that the student did have signed orders from the Doctor that the mother had brought in at the same time as the Diastat was brought in. Respondent states that the medication was entered into the student profile and into the emergency section.

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)(D),(1)(M),(1)(P),(1)(U)&(3)(A) and 22 TEX. ADMIN. CODE §217.12 (1)(A),(1)B),(1)(C),(1)(F)&(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 605004, and Vocational Nurse License Number 145206, heretofore issued to CHRISTINA DIANE REDDEN.

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 that RESPONDENT SHALL receive the sanction of **WARNING WITH STIPULATIONS** in accordance with the terms 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 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.

C. **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 four (4) quarterly periods [one (1) year]

of employment. This requirement will not be satisfied until four (4) 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. **Incident Reporting:** RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

D. **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 four (4) quarters [one (1) year] of employment as a nurse.

VI. 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 6th day of November 2020.

Christina Diane Redden

CHRISTINA DIANE REDDEN, RESPONDENT

Sworn to and subscribed before me this 6 day of November 2020.

SEAL

GIANA MARIE ORTIZ
Notary Public
STATE OF TEXAS
ID#131768540
My Comm. Exp. Oct. 23, 2022

Notary Public in and for the State of _____

Approved as to form and substance.

Giana Ortiz, Attorney for Respondent

Signed this 6 day of November 2020.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 6th day of November, 2020, by CHRISTINA DIANE REDDEN, Registered Nurse License Number 605004, and Vocational Nurse License Number 145206, and said Agreed Order is final.

Effective this 8th day of December, 2020.

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