DISCIPLINARY COMPLAINT RESOLUTION AGREEMENT

pursuant to section 55(2)(a.1) of the *Health Professions Act*

BETWEEN:

ADEYEMI ARAMIDE, #113,146
(the **"Registrant"**)

and

College and Association of Registered Nurses of Alberta
also known as **College of Registered Nurses of Alberta**
(the **"College"**)

A Disciplinary Complaint Resolution Agreement ("**DCRA**") was executed between the Registrant and the College, dated with effect **July 6, 2023**. The below constitutes a summary of such DCRA:

> Through a DCRA with the College, ADEYEMI ARAMIDE, #113,146 (the "**Registrant**"), acknowledged and admitted that their behaviour constituted unprofessional conduct. Particulars of the Registrant's unprofessional conduct arises from one (1) complaint to the College and includes the following:
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> - On one (1) occasion in July 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment in their care of Patient 1, who suffered a fall, when they: directed that the patient be transferred to the Emergency Room ("**ER**") without assessing the patient; failed to ensure continuity of care when they did not attend the ER with the patient to provide the patient's health history to the physician; failed to document their post-fall care of the patient in a timely manner; failed to complete the pain and behavior sections of the post-fall clinical monitoring documentation; and failed to document their administration of lorazepam in the Medication Administration Record ("**MAR**").

- On a separate occasion in July, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment in their care of Patient 2 when they: administered hydromorphone 2mg to the patient at 0900, which was not ordered, instead of morphine 2mg, which was ordered; administered hydromorphone 2mg to the patient at 1300, which was not ordered, instead of morphine 2mg, which was ordered; failed to review the MAR and/or the physician's orders before administering hydromorphone 2mg to the patient, which was not ordered, at 0900 and 1300; inaccurately, or alternatively inconsistently, documented the time the hydromorphone was administered to the patient in the interdisciplinary notes, the MAR and the narcotic record; failed to document in the MAR that the dose of morphine was held at 1300 and 1700; inaccurately documented the administration of morphine 2mg at 0900 in the MAR; and failed to adequately document the patient's vital signs.

- On one (1) occasion in April 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment when they administered double the ordered dose of perindopril to Patient 3.

The Registrant must complete coursework on medication management, documentation in nursing and the nursing process. The Registrant will be subject to a period of direct supervision in the workplace and must thereafter provide two (2) practice report letters indicating they are practicing at the standard expected of a RN. Conditions shall appear on the College register and on the Registrant's practice permit.