THE COLLEGE OF PHARMACISTS OF MANITOBA

In the matter of: ***The Pharmaceutical Act*, C.C.S.M., c.P60**

And in the matter of: **Rumina Ishani, a pharmacist registered with the College of Pharmacists of Manitoba**

DECISION AND ORDER OF THE DISCIPLINE COMMITTEE

Introduction

1. Pursuant to a Notice of Hearing dated May 1, 2026 (the "Notice"), a hearing was conducted by the Discipline Committee (the "Discipline Committee") of the College of Pharmacists of Manitoba ("CPhM") at the CPhM offices on July 14, 2026, with respect to charges formulated by the CPhM Complaints Committee (the "Complaints Committee") alleging that Rumina Ishani ("Ms. Ishani"), being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c. P60 (the "Act") and a registrant of CPhM, is guilty of professional misconduct, of conduct unbecoming a member, or of having displayed a lack of knowledge or skill or judgment in the practice of pharmacy, or any of the above, as described in section 54 of the Act, in that, at Shoppers Drug Mart #547, at 43 Marion Street, Winnipeg, Manitoba (the "Pharmacy"):

1. On or about August 12, 2025, with respect to patient "[redacted]" she:

    a. Dispensed the incorrect prescribed dose of aripiprazole to [redacted], and failed to identify and/or address drug therapy problems in that the dose dispensed was too high for [redacted] and increased the risk of [redacted] experiencing an adverse drug reaction and/or drug interaction, in contravention of sections 83(a), (b) and (e) of *The Pharmaceutical Regulation*, Man Reg 185/2013 (the "Regulation"), and sections 2.2.3 and 2.2.6 of the *Practice Direction: Ensuring Patient Safety* (the "Patient Safety PD"), or any of them; and

    b. Failed to correctly identify the patient and identify and/or address potential drug therapy problems with [redacted]'s prescription at the counselling step, in contravention of sections 56(1)1 of the Regulation, sections 2.2.3 and 2.2.6 of the Patient Safety PD, and sections 2.11.1 and 2.12.1 of the *Practice Direction: Patient Counselling* (the "Counselling PD"), or any of them.

2. The hearing into these charges convened on July 14, 2026. Mr. Jeffrey Hirsch, K.C. and Ms. Sharyne Hamm appeared as counsel for the Complaints Committee. Mr. Grant Stefanson, K.C. appeared as counsel for Ms. Ishani, who also attended in person. Mr. Thomas Reimer appeared as counsel for the presiding panel of the Discipline Committee (the "Panel").

3. The Complaints Committee and Ms. Ishani jointly submitted a Statement of Agreed Facts (the "Statement"), which was entered into evidence. In the Statement, Ms. Ishani admitted the following, with respect to jurisdiction, service, panel composition and practice and discipline history:

I. Jurisdiction, Service and Panel Composition

a. She is a member of CPhM.

b. She received valid service of the Notice.

c. CPhM has complied with the requirements of ss. 46(2) and 46(3) of the Act.

d. She has no objection to any of the Panel members, nor to legal counsel to the Panel, whether on the basis of bias, reasonable apprehension of bias, or conflict of interest.

II. Practice and Discipline History

e. Ms. Ishani graduated with her pharmacy degree from Massachusetts College of Pharmacy and Allied Health Sciences Boston in 1991.

f. She has been registered as a pharmacist under the Act since October 4, 2023. At all material times, she was a registrant of CPhM and a practising pharmacist in Manitoba.

g. Ms. Ishani's employment history is as follows:

i. Between 1992 and 1997, Ms. Ishani was licensed and practised as a pharmacist in Ontario;

ii. From 1997 to 2008, Ms. Ishani was a stay-at-home mother;

iii. Beginning in 2008, Ms. Ishani returned to the practice of pharmacy as a relief pharmacist in Ontario, after which she became the Owner and Designated Manager at a pharmacy in Toronto, a role she held from 2009 to 2021;

iv. Between 2022 and October 2023, Ms. Ishani practiced at Shoppers Drug Mart locations in Ontario;

v. From December 11, 2023, to May 2, 2025, Ms. Ishani was the pharmacy manager at Shoppers Drug Mart #533, at 1155 Main Street in Winnipeg;

vi. From March 2025 to June 2025, Ms. Ishani worked as a pharmacist at Tache Pharmacy in Winnipeg;

vii. From mid-June 2025 to August 2025, Ms. Ishani worked as a staff pharmacist at the Pharmacy (i.e. Shoppers Drug Mart #547 at 43 Marion Street in Winnipeg);

viii. Between August 2025 and December 2025, Ms. Ishani worked as a pharmacist at Rexall Pharmacy #4854 at 676 Portage Avenue in Winnipeg;

ix. Between January 2026 and March 2026, Ms. Ishani worked as a pharmacist at Rexall Pharmacy #7402 at the Assiniboine Clinic, 633 Lodge Avenue in Winnipeg;

x. Between March 2026 and May 2026, Ms. Ishani worked as a pharmacist at Rexall Pharmacy #4815 at 963 Henderson Highway in Winnipeg;

xi. Between May 2026 and June 2026, Ms. Ishani worked as a pharmacist at Shoppers Drug Mart #533, at 1155 Main Street in Winnipeg; and

xii. From June 2026 to the present time, Ms. Ishani has been employed at The Medicine Shoppe #278 at 115-1100 Concordia Avenue in Winnipeg.

h. Ms. Ishani has no previous discipline history with CPhM. However, she received two cautions during her time as a practising pharmacist in Ontario.

III. Admissions and Plea

4. Ms. Ishani admitted to having reviewed the Notice and the Statement, which her counsel and counsel for the Complaints Committee both signed. Ms. Ishani admitted the truth and accuracy of the facts in the Statement and admitted that the witnesses and other evidence available to the Complaints Committee would, if called and otherwise tendered, be substantially in accordance with these facts.

5. Ms. Ishani tendered no evidence and made no submissions on the issue of professional misconduct, other than to admit that the conduct described in the Statement demonstrates professional misconduct, a breach of the legislation, practice directions and guidelines, and a display of a lack of knowledge, skill or judgment in the practice of pharmacy as described in section 54 of the Act.

6. Ms. Ishani entered a guilty plea to counts 1(a) and 1(b) of the Notice (the "Charges").

7. Ms. Ishani agreed that her admissions and guilty plea were voluntary, informed and unequivocal. She also confirmed that she understood that by pleading guilty, she has given up her right to contest the factual accuracy of the allegations in the Charges.

IV. Disposition

8. Legal counsel for the Complaints Committee and for Ms. Ishani made a joint recommendation with respect to an appropriate disposition. At the hearing on the Charges, the Panel advised the parties that it accepted the joint recommendation, with written reasons to follow. Those written reasons are set out below.

V. Decision and Order

9. Considering the evidence contained in the Statement, together with Ms. Ishani's admission of guilt, the Panel accepts that the Charges have been established. It therefore finds Ms. Ishani guilty of professional misconduct and of displaying a lack of knowledge, skill or judgment in the practice of pharmacy, as described in s. 54 of the Act. The Panel accepts the joint recommendation and therefore makes the following orders, pursuant to ss. 55 and 56 of the Act:

a. Ms. Ishani will pay a fine of $3,500.00;

b. Ms. Ishani will pay a contribution to the costs of the investigation and hearing in the amount of $5,000.00; and

c. There will be publication of the conviction, penalty and circumstances of the offences, including publication of Ms. Ishani's name.

VI. Reasons for Decision

10. In reaching its decision, the Panel considered the Statement, the joint recommendation, the submissions of the parties, and the affidavit of Dr. Brent Booker affirmed July 13, 2026.

11. The following is a summary of the facts contained in the Statement. By her guilty plea, Ms. Ishani has admitted that the facts in the Statement breached the various provisions of the legislation, practice directions, and guidelines cited in the Charges at the beginning of this decision.

A. Summary of Facts

Background

12. The Charges arise out of a dispensing error that happened on August 12, 2025, when Ms. Ishani filled an aripiprazole prescription for a [redacted] patient. Aripiprazole is an antipsychotic drug, which can be used for many different indications. It carries a risk of QT interval prolongation, which affects the heart's rhythm.

13. The patient was first dispensed aripiprazole from the Pharmacy in November 2023, at a dose of 2mg/day for 30 days. That prescription was filled once. In February 2025, the patient was restarted on aripiprazole at a dose of 1mg/day, which was then increased to 2mg/day in March 2025. This prescription was filled monthly at the Pharmacy until August 2025.

14. At 11:05 a.m. on August 12, 2025, the Pharmacy received a prescription for the patient from their [redacted], which included a prescription for aripiprazole at the same 2mg dosage.

15. A pharmacy assistant performed the prescription intake at 11:27 a.m. and the data entry step at 11:44 a.m. Ms. Ishani verified the patient's prescriptions at 11:51 a.m., and the medications were packaged by another pharmacy assistant at 12:13 p.m. Ms. Ishani performed a product check at 12:39 p.m., and documented that counseling was completed at 12:41 p.m.

16. When the first pharmacy assistant performed the data entry step, [redacted] incorrectly entered 20mg as the dosage, instead of the prescribed 2mg. In completing the prescription verification step and the product check, Ms. Ishani did not notice that the wrong strength of aripiprazole had been selected. Ms. Ishani admitted that she did not scrutinize the drug utilization review or transaction notes appearing on the patient's prescription order when she performed the data verification step or when she performed the clinical verification step. Had she done so, she would have seen that there were drug interactions relevant to the aripiprazole prescription and another medication being dispensed to the plaintiff and that the dosage had been changed significantly from previous fills.

17. The complaint stated that Ms. Ishani provided no counseling with respect to the patient's prescriptions on August 12, 2025. Ms. Ishani stated that she did perform counselling on the order, and that she counselled on all prescriptions. However, Ms. Ishani stated that she did not look at the

computer screen to confirm the age of the patient, and she mistakenly thought that the adult [redacted] with the patient, a family friend, was the patient the aripiprazole was for.

18. The Pharmacy's pharmacy manager stated that the error should have been caught at the counselling step, and that the dose change would have been flagged in the HealthWatch system with a green flag to notify staff that the prescription was new or that there was a dose change.

19. During the counselling provided on the prescription, Ms. Ishani failed to correctly identify the patient and failed to identify the dose change and drug therapy problems, despite this information being present and visible on the computer counselling screen.

20. The patient took their first 20mg tablet on August 13, 2025, after which they were excessively drowsy throughout the day. They took a second 20mg dose on August 14, 2025, and became nauseous and vomited up the pill. The patient's [redacted] then saw that the pill bottle was labelled 20mg aripiprazole instead of 2mg and contacted poison control. The patient was taken to [redacted] Hospital and made a full recovery.

B. Disposition

21. After hearing submissions from counsel for the Complaints Committee and counsel for Ms. Ishani, the Panel advised the parties that it accepted the joint recommendation with written reasons to follow.

22. Ms. Ishani had three opportunities to recognize the error: at the prescription verification step, at the product check, and at the patient counselling step. Her sequence of failures to catch the mistake resulted in patient harm. Dispensing the incorrect strength of aripiprazole put the patient at risk of experiencing adverse effects of the drug and adverse effects from drug interactions and ultimately caused the patient's hospitalization. It is fortunate that the harm was not worse.

23. Ms. Ishani has not attempted to minimize her errors or deflect responsibility for them. The Panel accepts that she feels genuine remorse. She has shown insight and demonstrated an intention to improve her practice. She was also transparent and cooperative with CPhM's investigation and with the family, when they attended at the Pharmacy shortly after the incident.

24. In the Panel's view, the penalty proposed in the joint recommendation is proportionate to the misconduct to which Ms. Ishani has pled guilty. The penalty is consistent with the principles, and meets the objectives, of sentencing, including most importantly, the protection of the public and the maintenance of public confidence in the integrity of CPhM's ability to properly supervise its members' conduct.

25. This case is a good example of why proper verification and counselling is vital for safe and effective pharmaceutical practice. Pharmacists must take adequate time to complete these steps properly, so that similar medication errors can be prevented. The Panel finds that the fine and publication of this decision will be an adequate deterrent against similar misconduct in the future on the part of Ms. Ishani specifically and on the part of the profession generally. The penalty is also consistent with previous cases involving similar misconduct.

26. The Panel also finds that the parties' joint recommendation that Ms. Ishani contribute $5,000 to CPhM's costs is reasonable, proportionate, and consistent with the Panel's statutory discretion under ss. 56(1) and (2) of the Act.

VII. Conclusion

27. To summarize, pursuant to ss. 55 and 56 of the Act, the Panel orders that:

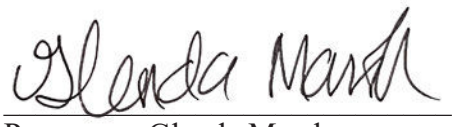
a. Ms. Ishani will pay a fine of $3,500.00;

b. Ms. Ishani will pay a contribution to the costs of the investigation and hearing in the amount of $5,000.00; and

c. There will be publication of the conviction, penalty and circumstances of the offences, including publication of Ms. Ishani's name.

DATED at Winnipeg, Manitoba, this 8th day of October, 2026.

THE COLLEGE OF PHARMACISTS OF MANITOBA



Per: Glenda Marsh
Chair, Discipline Panel