# COLLEGE OF PHARMACISTS OF MANITOBA

# 2022
## FALL NEWSLETTER

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This Newsletter is published four times per year by the College of Pharmacists of Manitoba (the College) and is forwarded to every licenced pharmacist and pharmacy owner in the Province of Manitoba. Decisions of the College of Pharmacists of Manitoba regarding all matters such as regulations, drug-related incidents, etc. are published in the newsletter. The College therefore expects that all pharmacists and pharmacy owners are aware of these matters.

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**The mandate of the College is to serve and protect the public interest**

Our mission is to protect the health and well-being of the public by ensuring and promoting safe, patient-centred and progressive pharmacy practice in collaboration with other health-care providers.

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FEATURE

# President's Message

Dear Colleagues,

It's a great time to be engaged with the pharmacy profession, with so much important work going on in practice. I feel privileged to be a part of Council as we continue to lead the College of Pharmacists of Manitoba (CPhM) in exciting new directions, as outlined in our Strategic Plan for 2021-2014.

CPhM has been hard at work with the implementation of several initiatives starting with ISMP Canada's Multi-Incident Analysis (MIA) of Incidents Associated with Harm Reported by Community Pharmacies in Manitoba. This report commissioned by CPhM represents the shared effort of community pharmacy professionals to report medication incidents to the National Incident Data Repository (NIDR) for Community Pharmacies which is a component of the Canadian Medication Incident Reporting and Prevention System. CPhM and the Safety IQ team commend pharmacy professionals' contributions to the NIDR and your efforts to reduce the chances of patient harm in your pharmacies. I strongly encourage pharmacy managers and CQI coordinators to read the full report and implement the recommendations into their pharmacy's practice.

In line with its mandate of public protection, CPhM recently announced the amendments to the Manitoba Pharmaceutical Regulation to expand Schedule 2 to permit the ongoing administration of COVID-19 vaccines by pharmacists and to update the name of the provincial immunization database. Thank you to everyone who participated in the public consultation.

In accordance with CPhM's strategic priorities to promote integrity, trust, and equity in pharmacy practice and regulation, all pharmacy professionals in Manitoba were sent direct correspondence from CPhM regarding the availability of the 2022 mandatory professional development (PD) module, Health Equity and Cultural Humility: An Introduction for Health Professionals in Manitoba.

The module was developed in collaboration with 16 provincial health regulatory colleges that are part of the Manitoba Alliance of Health Regulatory Colleges to support awareness and knowledge of health inequity. The participating colleges sourced subject matter experts to develop the module content, including an equity, diversity, and inclusion specialist and an Indigenous elder, heath care professional, and cultural safety trainer. While this module deals with health equity and cultural humility more generally, CPhM will continue to develop or provide subsequent education addressing Indigenous-specific racism. Pharmacists and pharmacy technicians are reminded that they have until **Dec. 31, 2022**, and May 31, 2023, respectively, to complete the module.

Amid cold and flu season, administering vaccines, staff shortages, and drug supply issues, pharmacy professionals have been hard at work helping patients manage their healthcare needs while coping with these challenges. CPhM sincerely thanks all pharmacy professionals and other frontline health providers for your tremendous efforts and dedication to meeting the high patient care and safety demands placed on you and your practice at this time.

Sincerely,

Jane Lamont

SAFETY. IMPROVEMENT. QUALITY.

# Safety Feature – Updated Incident Disclosure Framework Now Available

Every patient has the right to be informed about their healthcare. This includes the right to be promptly notified when a medication incident happens. According to the Medication Incident and Near-Miss Event Practice Direction (MINME), your pharmacy must have a documented policy and procedure for providing appropriate apologies and disclosures to patients following a medication incident. A robust policy and procedure combined with staff training can mean the difference between maintaining a trusted relationship with the patient, and a rupture in the care relationship that could prompt your patient to bring their concerns to the College of Pharmacists of Manitoba for resolution.

The proper disclosure of a medication incident can contribute many benefits to patients, loved ones, and the pharmacy professionals involved, including:

- Building a culture of safety through open, honest, and effective communication.
- Healing for the patient and/or family and pharmacy professionals involved in the incident.
- Learning from the incident to prevent recurrence through patient and pharmacy professionals' input.

**You are required to disclose medication incidents to patients, regardless of the level of harm caused by the incident.** Even when a 'no harm' incident occurs, you must disclose it to the patient including all the steps outlined in the MINME. Pharmacy professionals must use their professional judgement to decide on the extent of the disclosure because some incidents can be disclosed in a concise but present and meaningful conversation, while other incidents —especially those that cause severe harm or death — will require greater care and depth.

Disclosure is more than an apology, ensuring patient care, or providing the correct medication. It involves following through with incident analysis and sharing learnings with the patient in an honest and caring manner. Disclosure often involves more than one discussion with the patient and often occurs in two stages:

1. **Initial disclosure** including a discussion with the patient as soon as reasonably possible, focusing first on the immediate safety of the patient, apologizing and outlining the known facts at the time.

2. **Post-analysis disclosure** with a focus on learnings and recommended pharmacy changes to prevent recurrence.

The Safety IQ team has developed an updated Medication Incident Disclosure Framework and a case example to provide you with suggestions on how a medication incident should be disclosed to a patient, their agent, or a loved one.

Please visit Safety IQ Academy at the following link to access the disclosure framework:

https://safetyiq.academy/disclose-and-apologize/

## CPhM and ISMP Canada Publish Manitoba Community Pharmacy Medication Incident Data Analysis and Improvement Recommendations

The College of Pharmacists of Manitoba (CPhM) is pleased to present ISMP Canada's Multi-Incident Analysis (MIA) of Incidents Associated with Harm Reported by Community Pharmacies in Manitoba. A summary of the MIA report is available here. This report commissioned by CPhM represents the shared effort of community pharmacy professionals to report medication incidents to the National Incident Data Repository (NIDR) for Community Pharmacies which is a component of the Canadian Medication Incident Reporting and Prevention System.

Medication safety specialists at ISMP Canada analyse your anonymous aggregate reports and share them to promote provincial, national, and international learning about medication incidents and near-miss events in community pharmacy. This MIA report and summaries are one way your data is translated into actionable recommendations to improve pharmacy practice.

The MIA report looked at 3898 submissions to the NIDR from April 1, 2017 – March 31, 2022. A total of 137 incidents (3.5 per cent) were associated with harm and 90 per cent of errors were reported to have caused mild harm. Most incidents occurred in the order entry and dispensing stages of prescription processes. These findings are similar to other MIA of harm events in Canada including a CMAJ study (2018) and ISMP Canada Safety Brief (2020).

### How can we use this information to improve processes in our pharmacy?

- Read the full report and summary. CPhM strongly encourages pharmacy managers and CQI coordinators to read the full report to implement the report's recommendations into their pharmacy's practice. The report features a handy chart in the appendix that provides guidance to pharmacy managers on which recommendations pharmacy managers should implement as leaders and policy makers.
- Use the summary report as a topic for conversation during staff safety huddles. Some guiding questions for your safety huddle could include: How do the recommendations in the report compare with your pharmacy's current practices? Has your pharmacy experienced a similar incident or near-miss, and can the recommendations be part of a broader improvement plan?
- Post the summary throughout the pharmacy to prompt discussion among all staff about the MIA findings and recommendations.

CPhM and the Safety IQ team commend your contributions to the NIDR and your efforts to reduce the chances of patient harm in your pharmacies. If you have any questions or concerns about the MIA report, please contact us at safetyiq@cphm.ca.

## SAFETY MEASURES:

### New Provincial and National Data From the NIDR

Data matters! Statistical reports from the National Incident Data Repository (NIDR) for Community Pharmacies bring awareness to the common types of incidents and near-miss events in Manitoba and can focus the improvement efforts of pharmacy professionals and the College. Here are the latest medication incident, near-miss event, and engagement statistics reported by Manitoba's pharmacy professionals:

**217** is the average number of reports per month to the NIDR

Pharmacy professionals have reported **1356** medication incidents in 2022

Pharmacy professionals have reported **600** near-miss events in 2022

**383** Pharmacies have completed at least one formal Continuous Quality Improvement Meeting

**388** Pharmacies have completed their Safety Self-Assessment

## RESOURCES & PROFESSIONAL DEVELOPMENT OPPORTUNITIES:

### College of Pharmacists of Manitoba Resources

- Medication Incident Disclosure Framework and Case Example *NEW*
- How Are We Doing? Toolkit for Effective CQI Meetings
- Medication Incidents in COVID-19 Vaccine Administration in Children: Contributing Factors and Prevention Strategies

### Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy:

- 3 Tactics for Safer Drug Storage:
  Organization and awareness can help prevent medication incidents related to improper drug storage and look-alike, sound-alike drug mix-ups.
- 5 Key Points of the Teach Back Method for Patient Counselling:
  Boost patient health literacy while ensuring the correct medication goes to the correct patient with this simple approach to patient counselling.
- Don't Drop the Ball: Safer Handoffs in Community Pharmacy:
  Poor communication is one of the most common factors in medication incidents. Learn how standardized forms of communication can improve the safety and efficiency of prescription handoffs between pharmacy professionals on your team.

### ISMP Canada Safety Bulletins

- Optimizing Medication Safety in Virtual Primary Care (September 21, 2022)
- Safer Labelling of Repackaged Active Pharmaceutical Ingredients for Pharmacy Compounding (August 10, 2022)
- Infusion Errors Leading to Fatal Overdoses of N-Acetylcysteine (July 21, 2022)

### ISMP Canada Learning Opportunities

The following learning opportunities are available at https://ismpcanada.ca/education/:

- Incident Analysis and Proactive Risk Assessment
- Multi-Incident Analysis and Medication Safety Culture Assessment
- Medication Reconciliation and Best Possible Medication History
- Keeping Pediatric Patients Safe: Pediatric Safety Consideration for Community Pharmacists
- Application of TALLman Lettering for High Alert Drugs in Canada

# Education from the Adult Inquest Review Committee Meetings of the Chief Medical Examiner's Office

The College of Pharmacists of Manitoba attends monthly Adult Inquest Review Committee meetings at the Chief Medical Examiner's Office to review deaths, which may have involved prescription drugs, focusing on opioids and other drugs of abuse. A de-identified case study based on information obtained from these meetings is presented in each Newsletter to provide an opportunity for education and self-reflection for all pharmacists.

## Introduction

BC is a 47-year-old female who was found unresponsive in her bedroom on June 7, 2019. Emergency Medical Services responded but all resuscitation efforts were unsuccessful. Drug paraphernalia was found at the scene. BC had a past medical history of hypertension, hypothyroidism, uncontrolled type I diabetes mellitus, peripheral neuropathy, prior episode of diabetic ketoacidosis and end-stage renal disease requiring hemodialysis. In addition, her history included previous suicidal ideation, suicide attempt, and substance abuse with a recent fentanyl overdose one month prior to her death. This case was presented in a previous newsletter publication, however, different aspects of the care provided are explored in this edition.

The immediate cause of death was determined to be accidental mixed drug toxicity (cocaine, fentanyl, multiple non-opioid drugs (alprazolam, clonazepam, diphenhydramine, pseudoephedrine and zopiclone)). A significant condition contributing to her death was end-stage renal disease due to type I diabetes mellitus.

## Results

The following chart represents the results of the toxicology report. Drugs that were above the therapeutic range are indicated by an asterisk (*):

| Drug | Level in blood | Therapeutic Range (if applicable) |
|---|---|---|
| Alprazolam<br>Alpha-hydroxyalprazolam | 28 ng/mL<br>0 ng/mL | 25 – 55 ng/mL |
| Clonazepam<br>7-Aminoclonazepam<br>(Metabolite of clonazepam) | 0 ng/mL<br>111 ng/mL | 20 – 70 ng/mL<br>20 – 140 ng/mL |
| Diltiazem* | 614 ng/mL | 50 – 200 ng/mL |
| Fentanyl | 13.9 ng/mL | --<br>^within 24 hours of the application of a 100 ug/hr<br>transdermal patch, the expected serum concentration<br>is 1.9 – 3.8 ng/mL |
| Diphenhydramine* | 214 ng/mL | 14 – 112 ng/mL |
| Gabapentin | 5 ug/mL | 2 – 20 ug/mL |

| | | |
|---|---|---|
| Paroxetine* | 341 ng/mL | 31 – 62 ng/mL |
| Pseudoephedrine | 286 ng/mL | --<br>^following daily 360mg doses, plasma pseudoephedrine concentrations reach 640ng/mL. |
| Zopiclone | 32 ng/mL | 25 – 65 ng/mL |
| Ethanol | 11 mg/dL | -- |

**Note:** Selective serotonin-reuptake inhibitors like paroxetine undergo post-mortem redistribution and levels may be slightly elevated in the toxicology report.

BC's DPIN history below only includes a summary of the medications relevant to her toxicology results:

| Generic Name | Date Dispensed | Strength | Quantity | Days' Supply | Prescriber | Pharmacy |
|---|---|---|---|---|---|---|
| Clonazepam | May 11, 2019 | 2 mg | 500 | 100 | Dr. A | ABC Pharmacy |
| Acetaminophen/ Codeine | May 14, 2019 | 300/30 mg | 30 | 3 | Dr. A | ABC Pharmacy |
| Diltiazem | Apr 22, 2019<br>Apr 22, 2019<br>Feb 28, 2019<br>Feb 28, 2019 | 360 mg<br>180 mg<br>360 mg<br>180 mg | 90<br>90<br>60<br>60 | 90<br>90<br>60<br>60 | Dr. A | ABC Pharmacy |
| Gabapentin | Apr 22, 2019<br>Apr 3, 2019<br>Feb 28, 2019 | 100 mg | 40<br>60<br>60 | 40<br>60<br>60 | Dr. A | ABC Pharmacy |
| Hydromorphone (Controlled Release) | May 5, 2019<br>Apr 26, 2019<br>Apr 14, 2019<br>Apr 2, 2019<br>Mar 15, 2019<br>Mar 2, 2019<br>Feb 18, 2019<br>Feb 18, 2019 | 3 mg<br>6 mg<br>12 mg<br>18 mg<br>24 mg<br>30 mg<br>12 mg<br>24 mg | 28<br>28<br>28<br>28<br>28<br>14<br>28<br>28 | 14<br>14<br>14<br>14<br>14<br>14<br>14<br>14 | Dr. A | ABC Pharmacy |
| Lorazepam | May 27, 2019<br>May 5, 2019<br>Apr 30, 2019<br>Apr 21, 2019<br>Apr 14, 2019<br>Apr 1, 2019<br>Mar 15, 2019<br>Mar 1, 2019<br>Feb 25, 2019<br>Feb 18, 2019 | 1 mg | 84<br>84<br>42<br>84<br>84<br>84<br>84<br>84<br>28<br>56 | 14<br>14<br>7<br>14<br>14<br>14<br>14<br>14<br>7<br>14 | Dr. A | ABC Pharmacy |
| Paroxetine | Mar 1, 2019 | 20 mg | 180 | 90 | Dr. A | ABC Pharmacy |
| Quetiapine | Apr 3, 2019 | 25 mg | 90 | 90 | Dr. A | ABC Pharmacy |
| Zopiclone | May 10, 2019 | 5 mg | 180 | 90 | Dr. A | ABC Pharmacy |

## Discussion

As discussed in the previous publication of this case study, BC was rapidly tapered off hydromorphone-controlled release (CR) over the span of 14 weeks. This case study will focus on other factors that may have contributed to her death.

BC was receiving a combination of opioids, benzodiazepines, and other sedating agents. According to the medical examiner's report, although alprazolam, clonazepam, diphenhydramine, gabapentin and zopiclone are quantified in peripheral blood within their respective established therapeutic ranges, these drugs combined can result in central nervous system depression, respiratory depression, and higher risk of unintentional overdose death, particularly in combination with fentanyl. The use of gabapentin in combination with an opioid has been associated with an approximately 60% increase in the odds of opioid-related death.[1] The combination of other sedating agents with an opioid has been associated with a 2 to 3 times higher risk of opioid-related death.[2] The patient was at further risk of experiencing an overdose in the presence of pre-existing end-stage renal disease and a history of an overdose event involving fentanyl one month prior to her death. Moreover, there is no evidence to support the use of 2 or more sedative-hypnotic/anxiolytics and only 11% of patients experience meaningful improvement in function with the use of opioids.[3] A re-evaluation of BC's prescribed and non-prescribed medications, including their indication, efficacy, and safety, could be carried out as a starting point to recognize risky drug combinations and to recommend alternatives to reduce the risk of potential harm associated with her medications. Pharmacists can help create a gradual tapering schedule for one sedating medication at a time with frequent follow-up to reduce her risk. As mentioned in the previous newsletter, this patient could also have benefited from receiving a naloxone kit.

This patient had a history of early refills on lorazepam and gabapentin. Patients may report a need for an early refill due to a lost or stolen prescription, a need for additional supply while on vacation, and/or worsening or inadequate symptom control. A risk mitigation strategy pharmacists can apply is to ask patients questions to gain a better understanding about their pattern of medication use, document the reason for the early refill, and communicating this to their prescriber to address the underlying cause of the early refill and to explore potentially safer alternatives. Pharmacists are in an opportune position to identify these signs early, and to prevent progression from medication use to substance use disorder and/or medication-related harm and/or mortality.

Although hydromorphone and lorazepam were dispensed every 14 days, other sedatives were being dispensed every 60 – 100 days, resulting in large on-hand quantities for the patient. It is best practice to control the dispensing of all sedative drugs, giving smaller quantities at a time. According to the new Standard of Practice for Prescribing Benzodiazepines & Z-Drugs by the College of Physicians and Surgeons of Manitoba (CPSM) that was updated in November 2020, benzodiazepines and Z-drugs prescriptions can now only be written for a maximum of three months at once and only a one-month supply can be dispensed at a time.[4] Aligning the dispensing of all sedative medications can help reduce risk of overdose.[4]

The patient's history of suicide attempt is also of concern. While the cause of death was deemed accidental, it is also important to recognize that the first three months after discharge from psychiatric care poses the highest risk for suicide.[5] Screening or asking patients about thoughts of suicide will not increase the risk of suicide but will allow patients the opportunity to talk about it. There are a number of screening tools available to identify patients at risk for suicide and guidance on what to do, including the Columbia-suicide rating scale and ASQ. Providing patients with resources on accessing services for addiction and suicide is recommended, including the following:

- Rapid Access to Addictions Medicine Clinic (RAAM) located at CRC or River Point Centre is a drop-in clinic for individuals seeking help with high-risk substance use and addictions. Not for individuals needing urgent medical attention.

- Crisis Response Centre (CRC) located at 817 Bannatyne Avenue is a 24/7 drop-in for adults experiencing a mental health crisis.

- Mobile Crisis Service (204-940-1781) is a 24/7 phone service assisting individuals experiencing a mental health crisis

To summarize, the pharmacist is primarily responsible for prioritizing patient safety. Pharmacists must ensure they complete a thorough revision of each prescription, as well as address and correct potential issues before the medication is dispensed. All members are reminded of their professional obligation and must take measures to address issues with appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing. Pharmacists do not have the obligation to dispense medications that they believe may cause patient harm. In such cases, the patient must be referred appropriately according to the Referring a Patient Practice Direction.

**References:**


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2. Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert ASB. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. BMJ 2015;350.

3. J. Busse, S. Craigie, D. Juurlink, N. Buckley, L. Wang, R. Couban, T. Agoritsas, E. Akl, A. Carrasco-Labra, L. Cooper, C. Cull, B. da Costa, J. Frank, G. Grant, A. Iorio, N. Persaud, S. Stern, P. Tugwell, P. Vandvik and G. Guyatt, "Guideline for Opioid Therapy and Chronic Noncancer Pain," Canadian Medical Association Journal, pp. 189:E659-66, 2017.

4. Canadian Institute for Health Information (CIHI), "Opioid Prescribing in Canada: How Are Practices Changing?," Canadian Institute for Health Information, Ottawa, 2019.

5. Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. Suicide rates after discharge from psychiatric facilities: A Systematic Review and Meta-analysis. JAMA Psychiatry 2017;74(7):694-702.

# Decision and Order of the Discipline Committee: Robert R. Nieman

Pursuant to the Amended Notice of Hearing (the "Notice") dated August 22, 2019, a hearing was convened by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on March 28, 2022, with respect to charges formulated by the College alleging that Mr. Robert R. Nieman ("Mr. Nieman"), being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c.P60 (the "Act") and a registrant of the College, is guilty of professional misconduct, conduct unbecoming a member, or displayed a lack of skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above, as described in section 54 of the Act, in that, at Health Plus Pharmacy (the "Pharmacy"), 1075 Autumnwood Drive, Winnipeg, Manitoba, Mr. Nieman:

1. [STAY];

2. between February 2017 and April 2019, on approximately 14 acquisitions of controlled substances from a licenced dealer, delegated the task of ordering and receiving controlled substances to individuals who were neither qualified nor authorized to do so, in contravention of subsection 65(3) of the *Pharmaceutical Regulation,* Man Reg 185/2013 (the "Regulation");

3. between January 2017 and April 2019, failed to manage and control the controlled substances inventory, in that he:

    a. failed to enter inventory upon receipt of a controlled substance from a licenced dealer in contravention of section 30 of the NCRs, sections G.03.001 and G.03.012 of the *Food and Drug Regulations*, C.R.C. c. 870 (the "FDRs"), and Statement I of *The Code of Ethics* (the "Code"), or any of them;

    b. failed to maintain accurate inventory records by operating the pharmacy with an electronic inventory record of zero controlled substances on-hand, and an inaccurate manual inventory log, which did not reconcile with the actual physical on-hand inventory, in contravention of sections 30 and 43 of the NCRs, and sections 2.3.1, 2.3.2, 2.3.2.1, 2.3.2.3, and 2.3.2.4 of the *Practice Direction – Drug Distribution and Storage* (the "DDS Practice Direction"), or any of them;

    c. failed to investigate discrepancies in contravention of section 2.3.2.3 and 2.3.2.4 of the DDS Practice Direction, or either of them;

    d. on nine separate occasions between January 2017 and March 2019, failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada in contravention of section 42 of the NCRs, section G.03.013 of the FDRs, subsection 7(1)(b) of the *Benzodiazepines and Other Targeted Substances Regulations*, SOR/2000-217, and section 2.3.2.5 of the DDS Practice Direction, or any of them;

e. on nine separate occasions between January 2017 and March 2019, failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the College, in contravention of section 2.3.2.5 of the DDS Practice Direction, and Statement I of the Code, or either of them;

4. failed to implement policies and/or procedures necessary to protect controlled substances essential to the oversight of a pharmacist with sanctions imposed by the Discipline Committee in contravention of section 43 of the NCRs, and sections 2.3.1 and 2.3.2 of the DDS Practice Direction, or any of them;

5. [STAY];

6. in his role as a pharmacist, between January 2019 and April 2019, dispensed narcotics in excess of the prescriber's directions, in both the quantity and interval, with no or insufficient documentation of authorization from the prescriber, in contravention of subsection 31(2)(b) of the NCRs, subsection 69(1) of the Regulation, and Statements 2 and 7 of the Code, or any of them; and

7. in his role as a pharmacist, on December 13, 2018, failed to fulfill his duties in dispensing ketamine 10% compound for a patient, in contravention of section 43 of the NCR, in that he:

    a. a. failed to receive the ketamine powder and maintain accurate inventory records in contravention of section 30 of the NCR, and sections 2.1.1 and 2.3.2.1 of the DDS Practice Direction, or any of them; and,

    a. b. failed to safely dispense and label the ketamine 10% compound in contravention of subsections 70(1)(j), and 71(1)(d), (f), (g) of the Regulation, or any of them.

The hearing into the charges convened on March 28, 2022. Mr. Jeffrey Hirsch ("Mr. Hirsch") and Ms. Sharyne Hamm appeared as counsel on behalf of the Complaints Committee. Mr. Nieman appeared unrepresented before the Discipline Committee (the "Panel"). Mr. Joseph Pollock appeared as counsel on behalf of the Panel.

A Statement of Agreed Facts (the "Statement") was filed in which Mr. Nieman admitted:

1. his membership in the College.

2. valid service of the Notice and the Amended Notice of Hearing dated August 22, 2019, and that the College complied with the requirements of sub-sections 46(2) and 46(3) of the Act.

3. he had no objection to the composition of any of the Panel members or to legal counsel to the Panel on the basis of bias, a reasonable apprehension of bias or a conflict of interest.

4. he graduated with his pharmacy degree from the University of Manitoba in 2002.

5. he has been registered as a pharmacist under the Act since August 14, 2002.

6. he ceased to be a practicing pharmacist on January 1, 2021.

7. at all times material to this proceeding, he was a member of the College as a practising pharmacist in Manitoba.

8. 8. As of June 17, 2009, he, through a numbered company, became a 25% owner of the Pharmacy. He remained an owner until October 2020. He was also the pharmacy manager at the Pharmacy from June 17, 2009 until March 27, 2020.

9. 9. he had no previous discipline history with the College

**Plea**

Mr. Nieman entered a plea of guilty to counts 2, 3(a) – (e), 4, 6 and 7 as set out in the Notice.

The prosecution entered a stay of proceedings with respect to counts 1 and 5 as set out in the Notice.

The parties further agreed that:

**Regarding Count 2:**

At all material times, there were two pharmacists employed by the Pharmacy - Mr. Nieman and Mr. Shouren Bose.

The College disciplined Mr. Bose through a decision and order of the College's Discipline Committee dated March 3, 2015. The Discipline Order provided that:

a. Mr. Bose be suspended for one year, commencing July 8, 2014 and ending July 8, 2015;

b. During the time he was suspended, Mr. Bose was required:

   i. to complete a chemical abuse assessment approved by the Registrar and provide the Registrar with the findings;

   ii. to comply with all recommendations from the chemical abuse assessment and provide monthly reports in writing to the Registrar; and,

   iii. to make and maintain contact with the Pharmacists at Risk Committee and instruct the Committee to contact the Registrar should he fail to maintain a satisfactory relationship with the Committee;

c. Upon completion of the period of suspension, Mr. Bose was able to apply for re-instatement of his pharmacist license, subject to all of the re-licensing requirements of the College;

d. Upon relicensing with the College, the following conditions would be placed on Mr. Bose's license:

   i. He could not be a pharmacy manager;

   ii. He could not be a preceptor;

   iii. He could not have ordering / signing authority for drugs covered under the *Controlled Drugs and Substances Act*; and,

iv. He could not work in a pharmacy without another person present in the dispensary;

e. Upon relicensing with the College, Mr. Bose was required to advise the pharmacy manager in all pharmacies who employed him in some capacity that:

i. Monthly narcotic inventory verification counts must occur;

ii. Another pharmacist must verify all calculations for compounding medication before the compounding begins; and;

iii. He had restrictions placed on his license as set out above.

The Investigator conducted a review of the Pharmacy's narcotic records, and obtained records reflecting the narcotic substances ordered and received by the Pharmacy from the licensed dealer, McKesson Canada ("McKesson"). The McKesson records indicated the order date, quantity and name of the narcotic ordered, and the pharmacist placing the order.

The McKesson website requires a secure online password to place an order for narcotics. As a result of Mr. Bose's conditions, he did not have a narcotic password for the McKesson website. Mr. Nieman was the only pharmacist employed by the Pharmacy with a password for the McKesson website.

It was common practice at the Pharmacy for the pharmacy assistants to access the McKesson website to order narcotics using the secure online password of Mr. Nieman. Pharmacy assistants at the Pharmacy would order the narcotic drugs in question by accessing the McKesson website and finalizing the order with Mr. Neiman's secure online password. This process was followed when Mr. Nieman was not present in the Pharmacy and Mr. Bose was the only pharmacist present.

The Investigator reviewed the prescription files and compared them to the McKesson records. The Investigator determined that on approximately 21 acquisitions of 40 different controlled substances, Mr. Bose was the only pharmacist present in the Pharmacy when those narcotic orders were received.

The combination of DPIN records, prescription verification signatures and work schedules indicate that Mr. Bose was the pharmacist present in the Pharmacy on the dates the McKesson orders were received.

When narcotic drugs and controlled substances were received at the Pharmacy, the drugs would be unpacked by a pharmacy assistant, logged into the manual inventory log and stored in the Pharmacy safe. Mr. Bose would dispense the drugs to patients before Mr. Nieman could check and sign off on the order.

**Regarding Count 3(a)**

Section 30 of the Narcotic Control Regulations state that a pharmacist must immediately enter the receipt of narcotic drugs into the pharmacy's inventory system. This entry must include the name and quantity of the narcotic received, the date the narcotic was received, and the name and address of the person from whom the narcotic was received.

During the material time, it was the regular practice of the Pharmacy to only have one pharmacist on duty at a time, either Mr. Bose or Mr. Nieman. Mr. Nieman was present at the Pharmacy most Thursdays, Fridays, and every second Saturday and Sunday for an average of 24 hours per week. Mr. Bose was scheduled to work the remainder of the time. This schedule was at times flexible and subject to change.

Mr. Bose was unable to receive narcotic orders as a result of the sanctions on his practice imposed by the previous discipline committee order.

When Mr. Nieman was not present in the Pharmacy, the pharmacy assistants would receive the narcotic orders, unpack them and fill in the manual inventory logs. Because Mr. Nieman was not present in the Pharmacy on a daily basis, often many days would pass before Mr. Nieman would initial the invoices of narcotics and controlled substances received from McKesson. Mr. Nieman would regularly sign off on received narcotic orders that he had never physically seen.

**Regarding Count 3(b)**

Pharmacies are required to maintain a perpetual inventory with an accurate on hand count of all narcotic and controlled substances. This is central to the concept of narcotic accountability and works to ensure that there are adequate procedures in place to identify theft, loss or diversion of narcotic and controlled drugs.

During the inspection on April 16, 2019, the Investigator requested a computer-generated printout of the inventory levels of all narcotic drugs at the Pharmacy. The Investigator was informed that the Pharmacy was unable to produce such a printout as all of the counts were reset to zero by the dispensary software supplier approximately four days prior. No physical inventory count was completed prior to the reset.

The Investigator reviewed the manual perpetual logbook and conducted physical counts of five selected high-usage narcotics. There was an extreme variation in the actual and expected quantities in all five

| Drug | Expected Value | Actual Count | Short (Over) |
|---|---|---|---|
| HydromorphContin® 3mg | 186 | 127 | 59 |
| HydromorphContin® 12mg | 84 | 60 | 24 |
| Oxycocet ® | 1963 | 2044 | (81) |
| Apo-Methylphenidate® 10mg | 321 | 139 | 182 |
| PMS-Oxycodone® 5mg | 556 | 357 | 199 |

drugs, as follows:

The manual logbook system was not an effective nor accurate record of the narcotic and controlled substances on hand within the Pharmacy.

During the inspection on April 17, 2019, the Investigator requested a copy of the manual logbook to review. The Investigator was informed that the manual logbook had been taken home by a pharmacy assistant to be reconciled. Accordingly, on that date there was no way to determine the expected on-hand inventory levels of any narcotics or controlled substances.

The inability to check on-hand inventory counts to verify dispensed drugs presented a patient safety issue, as the Pharmacy was unable to accurately identify loss, theft, or potential dispensing errors.

**Regarding Count 3(c), 3(d) and 3(e)**

Pharmacy Managers are required to investigate discrepancies identified physical counts of narcotic and controlled drugs.

The Investigator reviewed the six most recent narcotic reports demonstrating counts conducted by the Pharmacy. The Investigator identified the following with respect to these narcotic reports:

a. November 13, 2018: This report indicated that the narcotic count was completed by a pharmacy assistant and initialled by Mr. Nieman. The report showed significant unexplained shortages for eleven separate controlled substances. There was no indication that any of these shortages were investigated by Mr. Nieman. There was no Loss and Theft Report prepared and the shortages were not reported to Health Canada or the College;

b. December 22, 2018: This report was printed and initialled by Mr. Nieman. There was no evidence of a physical count being conducted in connection with this report;

c. January 23, 2019: This report indicated that the narcotic count was conducted by a pharmacy assistant. Mr. Nieman initialled the report. The report showed significant unexplained shortages for four separate controlled substances. There was no indication that any of these shortages were investigated by Mr. Nieman. There was no Loss and Theft Report prepared and the shortages were not reported to Health Canada or the College;

d. February 19, 2019: This report indicated that the narcotic count was conducted by a pharmacy assistant. Mr. Nieman initialled the report. The report showed significant unexplained shortages for eight separate controlled substances. There was no indication that any of these shortages were investigated by Mr. Nieman. There was no Loss and Theft Report prepared and the shortages were not reported to Health Canada or the College;

e. March 21, 2019: This report indicated that the narcotic count was conducted by a pharmacy assistant. Mr. Nieman initialled the report. The report showed significant unexplained shortages for eight separate controlled substances. There was no indication that any of these shortages were investigated by Mr. Nieman. There was no Loss and Theft Report prepared and the shortages were not reported to Health Canada or the College; and

f. April 1, 2019: This report indicated that the narcotic count was conducted by a pharmacy assistant. Mr. Nieman initialled the report. There were no marks, amounts or any written indication that the stock was actually counted.

The Investigator reviewed count sheets maintained by the Pharmacy. In total, there were 23 instances on 9 separate occasions where there was a significant shortage in a narcotic or controlled substance and no Loss and Theft Report was provided to Health Canada or the College.

Following counts that indicated variation in the narcotic and controlled substances on hand in the Pharmacy, totals in the inventory log were simply adjusted, and no documentation existed to explain discrepancies. There is no evidence or documentation to indicate that an investigation of these discrepancies was ever conducted.

During the course of the investigation, Mr. Nieman stated that he had never submitted a Loss and Theft Report to either Health Canada or to the College except in two instances after break-ins at the Pharmacy on December 27, 2018 and February 22, 2019. In both of these break-ins, narcotic and controlled substances were stolen.

**Regarding Count 4**

In October of 2015, Mr. Bose began his employment at the Pharmacy under Mr. Nieman's management. Both Mr. Bose and Mr. Nieman signed a document which acknowledged that each was aware of the conditions set out in the Discipline Order.

The Investigator reviewed the Pharmacy's Policy and Procedures Manual (the "Manual") with respect to the provisions surrounding narcotic accountability. The sections of the Manual which dealt with narcotic policies, reporting and inventory management were inadequate. The Manual contained no information regarding ordering, receiving, signing and storage of documents, or investigating and reporting of shortages.

Due to the employment of Mr. Bose and his accompanying College discipline sanctions, it became a requirement of the Pharmacy Manager to conduct monthly rather than quarterly narcotic and controlled substance inventory counts.

The Investigator conducted a review of the Pharmacy's narcotic records. These records were stored in multiple locations throughout the Pharmacy and were not easily retrievable.

It was a regular practice at the Pharmacy for the pharmacy assistants to conduct the monthly counts and have the counts signed or initialled by Mr. Nieman at a later date. There existed a record of several recent monthly narcotic count reports being printed, but there was no evidence that a physical inventory count was also conducted. There was no evidence that Mr. Nieman was involved in the monthly counts.

**Regarding Count 6**

Prescriptions received at a pharmacy indicate, in writing, the quantity and interval of the drug prescribed by the healthcare practitioner. A pharmacist is not permitted to adapt a prescription to increase the number of milligrams dispensed or the interval on which they are dispensed without authorization from the prescribing healthcare practitioner. When verbal authorization is provided and permittable, the pharmacist is required to maintain a written record of such authorization, in accordance with the Regulation.

The Investigator reviewed the prescription files at the Pharmacy to evaluate whether proper narcotic dispensing practices were being followed.

Patient "A", was prescribed a tapering dose of opioid drugs. A prescription, dated January 10, 2019, for HydromorphContin 12mg capsules was observed, with the physician's instructions to provide one capsule three times per day, to be dispensed on Mondays, Wednesdays and Fridays.

The Investigator reviewed the dispensing records for Patient "A". and determined that the physician's orders were not being adhered to. Mr. Nieman, without first consulting the prescribing physician, switched the patient to daily dispensing and dispensed outside of the healthcare practitioner's instructions as the patient had consumed his entire supply of the narcotic on the first day. Mr. Nieman advised the prescribing healthcare practitioner of this change to the prescription at a later date.

As a result of this change in the prescription by Mr. Nieman, the patient was to receive three capsules of HydromorphContin 12mg each day. A review of the dispensing records from January of 2019 showed one instance where the patient was supplied with seventeen capsules of HydromorphContin 12mg by Mr. Nieman, instead of three. The dispensing records from February of 2019 show two instances

where the patient was supplied with six capsules of HydromorphContin 12mg on a daily basis by Mr. Nieman, instead of three, and one instance where the patient was supplied with four capsules of HydromorphContin 12mg on a daily basis by Mr. Nieman, instead of three.

The dispensing records for Patient "A" did not show any written record of the prescribing physician authorizing the change from three capsules daily to seventeen, six or four capsules daily.

**Regarding Count 7**

On December 13, 2018, the Pharmacy received a prescription for 150g of ketamine 10% compound from Patient "A". The Pharmacy did not regularly stock ketamine.

In an effort to avoid ordering excess ketamine, the Pharmacy contacted another community pharmacy (the "Pharmacy 2") to confirm whether they had ketamine in stock. It was confirmed that Pharmacy 2 had an inventory of 15g of ketamine. Mr. Nieman wrote a prescription for the ketamine to be transferred to the Pharmacy from Pharmacy 2.

A pharmacy assistant prepared labels for the ketamine while at the Pharmacy, and then drove to Pharmacy 2 to pick up the ketamine prescription. The pharmacy assistant then brought the ketamine to a third pharmacy ("Pharmacy 3") where she compounded it in the presence of another pharmacist who applied the labels. The other pharmacist performed the final check on the prescription.

Mr. Bose went to Pharmacy 3 where he picked up the prescription and delivered it to the patient.

The ketamine compound was not entered into the inventory of the Pharmacy for over one month from when the prescription was dispensed. Mr. Nieman played no role in the dispensing and labelling of the ketamine 10% compound

**Submission on Penalty**

Counsel for the Complaints Committee and Mr. Nieman made a joint recommendation on disposition, that in accordance with section 54, 55 and 56 of the Act that Mr. Nieman:

a. pay a fine of $5,000.00;

b. upon resumption of practice, be prohibited from being a pharmacy manager or preceptor for a period of ten years, commencing upon the date of relicensure; and,

c. pay a contribution to the costs of the investigation and hearing in the amount of $8,000.00.

The parties submitted that the joint recommendation on disposition appropriately balanced the protection of the public interest and fairness to Mr. Nieman and would not bring the administration of justice into disrepute or be otherwise contrary to the public interest.

After reviewing the authorities, documentary evidence, the agreed facts and the joint recommendation of disposition, the Panel found Mr. Nieman guilty of professional misconduct, having displayed a lack of knowledge or lack of skill or judgment in the practice of pharmacy, and conduct unbecoming a member in accordance with section 54 of the Act. pertaining counts 2, 3(a) – (e), 4, 6 and 7.

After having reviewed the authorities provided to the Panel regarding joint recommended dispositions and the joint recommendation submitted by the parties, the panel ordered that Mr. Nieman:

a. pay a fine of $5,000.00;
b. upon resumption of practice, be prohibited from being a pharmacy manager or preceptor for a period of ten years, commencing upon the date of relicensure; and,
c. pay a contribution to the costs of the investigation and hearing in the amount of $8,000.00.

In arriving at its decision, the Panel considered Mr. Nieman's admissions of guilt and the cooperative discussions between the parties.

Based on the foregoing, the Panel is satisfied that this disposition should serve to act as a deterrent, both general and specific, while at the same time ensuring that the public's interest is protected and the public's confidence is maintained.

DATED at Winnipeg, Manitoba this 14th day of June, 2022.

# Decision and Order of the Discipline Committee: Judy Lee-Wing

Pursuant to the Notice of Hearing dated February 11, 2021 (the "Notice"), an Amended Notice of Hearing dated March 8, 2021 (the "Amended Notice") and a Re-Amended Notice of Hearing dated June 22, 2022 (the "Re-Amended Notice"), a hearing was conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the law offices of Thompson Dorfman Sweatman LLP, Suite 1700 at 242 Hargrave Street, Winnipeg, Manitoba on June 27, 2022, with respect to charges alleging that Judy Lee-Wing, being a pharmacist under the provisions of The Pharmaceutical Act, C.C.S.M. c.P60 (the "Act") and a registrant of the College, is guilty of professional misconduct, conduct unbecoming a member, or has displayed a lack of knowledge, skill or judgment in the practice of pharmacy, or operation of a pharmacy, or any of the above, as described in section 54 of the Act, in that, in or about 2019 she:

1. operated an unlicensed pharmacy at 2251 Pembina Highway, Winnipeg, Manitoba, in contravention of section 63 of the Act;

2. without authorization, purchased cannabis from a person not authorized to sell cannabis, in contravention of section 101.14 of The Liquor and Gaming and Cannabis Control Act, C.C.S.M. c. L153 (the "LGCCA");

3. [STAY];

4. compounded a preparation using a drug not authorized for sale in Canada in contravention of section 80 of the Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation");

5. failed to document and keep a record of the compounding activities in contravention of section 8.0 of the Extemporaneous Compounding Guideline; section 7.2.1 of the NAPRA guidelines to Pharmacy Compounding-October 2006; sections 56(1)12 and 79(3) of the Regulation; and sections 2.1.1, 2.1.2 and 2.1.3 of the Practice Direction-Records and Information, or any of them;

6. without authorization sold and/or distributed CBD, an illicit cannabis product, in contravention of section 69(1) of the Cannabis Act, section 101.13(1) of the LGCCA, section 4 of the Pharmaceutical (General Matters) Regulation 194/2013, and section 80(a) of the Regulation, or any of them;

7. dispensed a drug without a valid prescription in contravention of section 171(b) of the Cannabis Regulations SOR/2018-144, section 2(3) of the Act, and section 69(1) of the Regulation, or any of them;

8. failed to obtain the required professional liability insurance as a practicing pharmacist in contravention of sections 14(e) and 123 of the Regulation, or either of them;

9. promoted cannabis via your website "canna-care.ca" in contravention of subsections 17(1) a and (c) of the Cannabis Act, sections 126(1), 126(2) and 129(1) of the Regulation, and section 2.12 of the

Practice Direction-Advertising in Manitoba, or any of them; and

10. [STAY].

At the hearing, Jeff Hirsch attended as legal counsel to the Complaints Committee, David Marr attended as legal counsel to the Panel of the Discipline Committee (the "Panel"), and Jennifer Sokal attended with, and as legal counsel to, Judy Lee-Wing.

A Statement of Agreed Facts was filed in which the parties agreed to the following:

I. Jurisdiction, Service and Panel Composition

1. Judy Lee-Wing admitted her membership in the College of Pharmacists of Manitoba (the "College").

2. A Notice of Hearing was issued on February 11, 2021.

3. The prosecution prepared and served an Amended Notice of Hearing to add an additional count.

4. The prosecution prepared and served a Re-Amended Notice of Hearing.

5. Ms. Lee-Wing admitted valid service of the Notice, Amended Notice, and the Re-Amended Notice and that the College complied with the requirements of sub-sections 46(2) and 46(3) of the Act.

6. Ms. Lee-Wing had no objection to any of the Panel members nor to legal counsel to the Panel on the basis of bias, a reasonable apprehension of bias, or a conflict of interest.

II. Practice and Discipline History

7. Ms. Lee-Wing graduated with her pharmacy degree from the University of Manitoba in 1991.

8. Lee-Wing was registered as a pharmacist under the Act commencing on July 18, 1991.

9. At all times material to this proceeding, Ms. Lee-Wing was a member of the College as a practising pharmacist in Manitoba.

10. Ms. Lee-Wing has a lengthy employment history, as follows:

    a. July 1991 to January 1994: Ms. Lee-Wing was employed by Metro Drugs at multiple locations;

    b. January 1994 to November 1994: Ms. Lee-Wing was employed as pharmacy manager at The Medicine & Health Shop;

    c. November 1994 to December 2000: Ms. Lee-Wing was employed as a pharmacy manager at Zellers, during which time she also took a maternity leave;

    d. Beginning in December 2000, Ms. Lee-Wing was self employed;

    e. May 2001 to May 2002: Ms. Lee-Wing was employed at Churchill RHA Inc. Pharmacy;

    f. May 2002 to November 2002: Ms. Lee-Wing was employed at Point Douglas Pharmacy;

    g. November 2002 to June 2003: Ms. Lee-Wing was employed at Al-Shifa Pharmacy;

h. June 2003 to May 2004: Ms. Lee-Wing was employed at Drugstore Pharmacy on Kenaston Blvd.;

i. May 2004 to July 2004: Ms. Lee-Wing was employed at Drugstore Pharmacy on Bison Drive;

j. July 2004 to August 2004: Ms. Lee-Wing was employed at The Medicine Chest;

k. November 2004 to November 2006: Ms. Lee-Wing was employed at Drugstore Pharmacy on Bison Drive;

l. November 2006 to May 2008: Ms. Lee-Wing was employed at Pharmasave on Grant Avenue;

m. February 2009 to September 2010: Ms. Lee-Wing was employed at Alentex Pharmacy;

n. Ms. Lee-Wing became employed as a pharmacist at St. Amant Inc. Pharmacy in September 2010;

o. Between June 19, 2015 and November 21, 2018, she was employed in the Pharmacy Department of the Winnipeg Regional Health Authority;

p. Ms. Lee-Wing was not listed on the College Registry as being employed between November 21, 2018 and December 3, 2019, at which time she was listed as being self-employed and doing relief work;

q. From October 8, 2020 to December 1, 2021, Ms. Lee-Wing was employed at Innomar Pharmacy, 179 Commerce Drive in Winnipeg, Manitoba;

r. From December 1, 2021 to December 26, 2021, Ms. Lee-Wing was employed in the Pharmacy Department of Shared Health;

s. From December 26, 2021 to January 25, 2022, Ms. Lee-Wing was employed by Rexall Pharmaplus on 35 Lakewood Boulevard in Winnipeg, Manitoba; and

t. From January 25, 2022 to the present date, Ms. Lee-Wing has been employed by Rexall Pharmaplus on 971 Corydon Avenue in Winnipeg, Manitoba.

11. Ms. Lee-Wing has no previous discipline history with the College.

Regarding admission and plea, the Statement of Agreed Facts stated that:

12. Ms. Lee-Wing has reviewed the Re-Amended Notice as well as the Statement of Agreed Facts (the "Statement"), admitted the truth and accuracy of the facts in the Statement and that the witnesses and other evidence available to the College would, if called and otherwise tendered, be substantially in accordance with these facts.

13. Ms. Lee-Wing tendered no evidence and made no submissions on the issue of professional misconduct, other than to admit that the conduct hereinafter described demonstrates professional misconduct as described in section 54 of the Act.

14. Ms. Lee-Wing agreed to and did enter a plea of guilty to counts 1, 2, 4, 5, 6, 7, 8 and 9 as set out in the Re-Amended Notice.

15. The Complaints Committee agreed to and entered a stay of proceedings with respect to counts 3 and 10 of the Re-Amended Notice.

**Count 1**

1.1 Count 1 alleges that Ms. Lee-Wing, in or about 2019, operated an unlicensed pharmacy at the Premises in contravention of section 63 of the Act. Section 2(1) of the Act states that the practice of pharmacy consists of the following practices, among others:

a. the compounding, dispensing and retail sale of drugs;

b. monitoring drug therapy and advising on the contents, therapeutic values and hazards of drugs; and

c. identifying and assessing drug-related problems and making recommendations to prevent or resolve them.

1.2 The Act defines a ''pharmacy" as "a facility used for any aspect of the practice of pharmacy, in cluding a satellite facility and every other facility, wherever located, used in the practice."

1.3 The Act defines a "pharmacy license" as "a licence of any category authorizing the operation of a pharmacy, and issued to an owner."

1.4 Ms. Lee-Wing held a practicing pharmacist's license in 2019. There was no pharmacy license issued for the Premises in 2019.

1.5 It was Ms. Lee-Wing's practice at the Premises to consult with patients with respect to the use of CBD and to dispense or sell CBD to patients. She also provided counselling and information about the use of CBD to patients who attended at her office at the Premises. Ms. Lee-Wing also provided information regarding other prescription drugs to patients, as well as altered patients' over the counter drug therapy and conducted medication reviews with patients.

1.6 During the initial site visit, Ken Zink, a Field Officer for the College, observed and photographed a sign on the door of Ms. Lee-Wing's office at the Premises. The sign identified Ms. Lee-Wing as a "Pharmacist Consultant."

1.7 During this period, Ms. Lee-Wing operated a website, Canna-Care.ca (the "Website") on which she indicated that she was a licensed pharmacist.

1.8 Ms. Lee-Wing admits her conduct described above constitutes the operation of a pharmacy by her, and further admits that at no time were the Premises licensed by the College to operate as a pharmacy.

**Count 2**

2.1 Count 2 alleges that Ms. Lee-Wing, without authorization, purchased cannabis from a person not authorized to sell cannabis, in contravention of section 101.14 of the LGCCA.

2.2 All phytocannabinoids are regulated under the Cannabis Act. CBD is a phytocannabinoid produced by the cannabis plant. CBD and products containing CBD are subject to all of the rules and requirements that apply to cannabis under the Cannabis Act and its Regulations. This

includes CBD derived from industrial hemp plants, as well as CBD derived from other varieties of cannabis.

2.3 CBD and all products containing CBD, such as cannabis oil, can only be possessed for sale and sold by a provincially or territorially authorized cannabis retailer or federally-licensed seller of cannabis for medical purposes.

2.4 For a few months prior to November 14, 2019, Ms. Lee-Wing operated a CBD dispensary in the Premises, providing both topical and oral CBD remedies to her patients.

2.5 During the November 14, 2019 site visit, Mr. Zink asked Ms. Lee-Wing to identify her CBD supplier. Ms. Lee-Wing initially refused to divulge her CBD source but did subsequently admit that her supplier was an unauthorized and unlicensed cannabis provider.

2.6 During the November 14, 2019 site visit, Mr. Zink observed a large inventory of CBD products, which Ms. Lee-Wing admitted to selling for both topical and oral use.

2.7 On November 3, 2020, in response to an inquiry made by Mr. Zink, Ms. Lee-Wing advised by email that her supplier for her CBD products was Okanagan CBD.

2.8 On November 13, 2020, Mr. Zink phoned Okanagan CBD and was advised by a customer service representative that Okanagan CBD sources their CBD from hemp oil from North American organic farms. The customer service representative admitted that Okanagan CBD was not a federally licensed or provincially authorized supplier of CBD.

**Count 4**

4.1 Count 4 alleges that Ms. Lee-Wing, in or about 2019, compounded a preparation using a drug not authorized for sale in Canada in contravention of section 80 of the Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation").

4.2 Section 80 of the Regulation prohibits members from selling, dispensing or using in a compounded preparation any drug that is not authorized for sale by Health Canada.

4.3 CBD is not authorized for sale by Health Canada.

4.4 During his site visit on November 14, 2019, Mr. Zink observed a large inventory of CBD products, as well as vegetable and olive oil dilutants, weighing scales and glassware.

4.5 During the relevant period, the Website indicated: "For a nominal fee, Cannaderm safely and professional incorporates your own CBD oil into an over-the-counter (OTC) base that is appropriate for you.".

4.6 During the course of the investigation, Mr. Zink and others at the College requested that Ms. Lee-Wing provide documentation of her practice. Ms. Lee-Wing stated that any documents she kept with respect to dispensing CBD from the Premises were damaged by a flood in her garage and were thrown away.

4.7 Mr. Zink obtained patient records for 133 patients from Pembina Medical Centre which also operated out of the Premises.

4.8 In the patient records for at least 11 patients, Ms. Lee-Wing documented that she compounded

and provided topical preparations using CBD in combination with certain over-the-counter drugs, including methyl salicylate, triethanolamine, diclofenac, Lanacane and triethanolamine, triethanolamine and methyl salicylate, and Anusol Plus and zinc oxide.

**Count 5**

5.1 Count 5 alleges that Ms. Lee-Wing, in or about 2019, failed to document and keep a record of the compounding activities in contravention of section 8.0 of the Extemporaneous Compounding Guideline, section 7.2.1 of the NAPRA Guidelines to Pharmacy Compounding – October 2006, subsections 56(1)12 and 79(3) of the Regulation and sections 2.1.1. 2.1.2 and 2.1.3 of the Practice Direction-Records and Information (the "RI-PD"), or any of them.

5.2 Section 8.0 of the Extemporaneous Compounding Guideline requires that a pharmacist document, on a dispensing worksheet or on the reverse of the prescription, certain information regarding the compounding of the drug. This information includes the patient name, compound name and strength, name, manufacturer and lot number of each raw material used, the formulation stating quantity and percent weight or volume of each raw material, and a description of each step and equipment used in the compounding process, among other things.

5.3 The Regulation and the RI-PD require that a pharmacist create, maintain and retain records as required under the Act.

5.4 During the course of the investigation, Mr. Zink and others at the College requested that Ms. Lee-Wing provide documentation of her practice. Ms. Lee-Wing stated that any documents she kept with respect to dispensing CBD from the Premises were damaged by a flood in her garage and were thrown away.

5.5 Ms. Lee-Wing was unable to produce any documentation which appropriately recorded her com pounding activities, as described in Count 4 herein.

**Count 6**

6.1 Count 6 alleges that Ms. Lee-Wing, in or about 2019, without authorization, sold and/or distributed CBD, an illicit cannabis product, in contravention of subsections 69(1) of the Cannabis Act, section 101.13(1) of the LGCCA, section 4 of the Pharmaceutical (General Matters) Regulation, 194/2013, and section 80(a) of the Regulation, or any of them.

6.2 Unless authorized pursuant to the Cannabis Act and provincial legislation, it is prohibited to possess, sell or distribute cannabis.

6.3 The Cannabis Act defines illicit cannabis as cannabis that was not obtained from an authorized and licensed provider.

6.4 During the November 14, 2019 site visit, Ms. Lee-Wing admitted to Mr. Zink that she was selling CBD for both topical and oral use.

6.5 At the time, neither Ms. Lee-Wing nor her business under the Website name of Canna-Care.ca were listed on the Health Canada website as a licensed supplier of cannabis. Ms. Lee-Wing was also not in possession of a federal exemption to sell cannabis.

**Count 7**

7.1 Count 7 alleges that Ms. Lee-Wing, in or about 2019, dispensed a drug without a valid prescription in contravention of subsection 171(b) of the Cannabis Regulations, SOR/2018-144 (the "Cannabis Regulations"), subsection 2(3) of the Act, and section 69(1) of the Regulation, or any of them.

7.2 Subsection 171(b) of the Cannabis Regulations permits a pharmacist to sell, distribute or administer a prescription drug to a person if the sale, distribution or administration is in accor dance with a written order or prescription signed and dated by a practitioner.

7.3 Subsection 69(1) of the Regulation prohibits a drug from being dispensed without authorization from a practitioner, whether verbally or in writing.

7.4 Based upon the records obtained through the Pembina Medical Clinic, from August 2, 2019 to November 18, 2019, Ms. Lee-Wing dispensed CBD to 133 patients. There are no prescription records for any of these 133 patients.

Count 8

8.1 Count 8 alleges that Ms. Lee-Wing, in or about 2019, failed to obtain the required professional liability insurance as a practicing pharmacist in contravention of sections 14(e) and 123 of the Regulation, or either of them.

8.2 Section 123 of the Regulation requires all members to be covered by professional liability insurance that provides a minimum of $2,000,000.00 of coverage per claim or per occurrence and a minimum $4,000,000.00 annual aggregate.

8.3 Section 14(e) of the Regulation requires applicants for a pharmacist license to provide a declaration that they are covered by professional liability insurance in accordance with section 123.

8.4 Ms. Lee-Wing was registered as a practicing pharmacist in 2019.

8.5 On Ms. Lee-Wing's application for a 2019 practicing pharmacist's license, she declared that she was covered for professional liability insurance that met the requirements of section 123 of the Regulation.

8.6 At Mr. Zink's request, Ms. Lee-Wing provided him with copies of all her recent insurance documentation.

8.7 These documents show that she had professional liability insurance in the amount of $1,000,000.00 per claim and a $1,000,000.00 annual aggregate for the period from July 1, 2018 to June 30, 2019. Ms. Lee-Wing did not have insurance for the period of July 1, 2019 to November 29, 2019, at which time she purchased new professional liability coverage with the statutorily required limits.

**Count 9**

9.1 Count 9 alleges that Ms. Lee-Wing, in or about 2019, promoted cannabis via the website Canna-care.ca in contravention of subsections 17(1)(a) and (c) of the Cannabis Act, section 126(1) and (2) and 129 of the Regulation, and section 2.12 of the Practice Direction – Advertising in Manitoba, or any of them.

9.2 Subsections 17(1)(a) and (c) of the Cannabis Act prohibit the promotion of cannabis, or any service related to cannabis, including by communicating information about its price or distribution or by means of a testimonial or endorsement.

9.3 Subsection 126(2) of the Regulation requires members to ensure that any advertising is factual, does not use descriptive or qualifying words such as "professional", "trusted", "prompt", "licensed", etc., does not use the word "specialist" or a word with similar meaning, and is in keeping with the honour and integrity of the image of a pharmacist and the practice of pharmacy.

9.4 Section 129 of the Regulation allows for the advertising of the price of a prescription drug and the fee for dispensing it so long as certain conditions are met.

9.5 Section 2.12 of the Practice Direction – Advertising in Manitoba Pharmacies states that advertising shall not contravene federal legislation regarding drugs, diseases or natural health products.

9.6 The Website for Ms. Lee-Wing's business included certain claims, including:

a. "Highly effective in relieving pain, swelling and muscle stiffness"; and

b. "Our remedies are of high quality and have proven therapeutic value".

9.7 The Website for Ms. Lee-Wing's business also included testimonials from previous customers, which included statements such as:

a. "Amazing product. Thank you, Judy";

b. "It's just amazing"; and

c. "Her consult is worth every penny. The tincture works great".

9.8 Ms. Lee-Wing promoted the fact that she was a licensed pharmacist while carrying on her CBD business. On her office door at the Premises, she displayed a poster which listed her name, contact information and the title "Pharmacist Consultant".

9.9 Ms. Lee-Wing also maintained a Facebook page, which identified her as both a pharmacist and pharmacist consultant, while at the same time including that she provided CBD topicals to patients. The Website also made numerous references to the fact that she was a licensed pharmacist, including the following phrases with respect to her CBD remedies:

a. "developed by a licensed pharmacist in Canada";

b. "we have over 25 years of diverse experience in pharmacy including caring for people in the community, long term care, and in the hospital";

c. "Our pharmacist plays a much-needed role in working to ensure the safe and appropriate use of cannabis"; and

d. "Our pharmacists can help to identify possible drug-related problems, interactions, side effects, and adverse drug reactions which might occur in combination with CBD."

Upon considering the Agreed Statement of Facts, this Panel finds pursuant to section 54 of the Act that Judy Lee-Wing is guilty of professional misconduct, conduct unbecoming a member and has displayed a lack of knowledge or skill or judgment in the practice of pharmacy or in operation of a pharmacy and, therefore pursuant to section 56 of the Act, this Panel ordered that Judy Lee-Wing:

1. pay to the College as a contribution towards the costs of the investigation and hearing the sum of $7,500.00 on or before June 27, 2023;

2. pay to the College a fine of $4,500.00 on or before June 27, 2023; and,

3. pursuant to section 55(3) of the Act, may not be a pharmacy manager or preceptor for a period of five (5) years commencing on February 11, 2021.

In arriving at its decision, the Panel considered Ms. Lee-Wing's admissions of guilt which alleviated what would have been a lengthy and complicated hearing, and her lack of any prior history of discipline, and is satisfied that this disposition should serve to act as a deterrent to her and in general, while at the same time ensuring that the public interests are protected and the public's confidence is maintained.

DATED at Winnipeg, Manitoba this 18th day of August, 2022.

Shannon Trapp
Panel Chair

# Pharmacist Licensure Decisions

1. Effective April 26, 2022, the practicing licence of Mr. Peter Kovac (CPhM Licence No. 14915) has been interim suspended by the Registrar pending a review of the matter by the complaints committee, in accordance with section 24(1) of *The Pharmaceutical Act.*

   Publication of this notice is pursuant to section 132(3) of the Pharmaceutical Regulation.

2. Effective May 6, 2022, the Registrar has issued an interim suspension of the practicing license of Mr. Garth Yelland (College Licence No. 24501) under section 24(1) of *The Pharmaceutical Act*, pending review of the matter by the Complaints Committee.

   Publication of this notice is pursuant to section 132(3) of the Pharmaceutical Regulation.

3. Effective July 8, 2022, the Registrar issued an interim suspension of the practicing license of Mr. Michael Watts (College Licence No. 31891) under section 24(1) of *The Pharmaceutical Act*, pending review of the matter by the Complaints Committee.

   Publication of this notice is pursuant to section 132(3) of the Pharmaceutical Regulation.

# In Memorium

*In loving memory,*

BRIAN MCCLURE
SEPTEMBER 13, 2022

BOHDAN JAWORSKI
OCTOBER 16, 2022

DONALD BRAUN
NOVEMBER 16, 2022