College of Pharmacists of Manitoba

NEWSLETTER

SUMMER 2025

INSIDE THIS EDITION:

Safety IQ Feature

Explore essential onboarding strategies for new pharmacy staff, including introducing Safety IQ principles, ensuring clarity about safety roles, and aligning team members with the pharmacy's safety goals from day one.

CPhM Hospital Standards and Guidelines (2004) Overhaul

CPhM has launched the Hospital Pharmacy Practice Direction Project to modernize hospital pharmacy standards and improve patient safety. Learn more and get involved on page 5.

Our purpose is to regulate the pharmacy profession with a commitment to excellence in person-centred, evidence-informed, and timely pharmacy care for all people. We serve the public interest by ensuring all pharmacy professionals are qualified to provide safe, ethical, and culturally sensitive care, free from all forms of racism, including Indigenous-specific racism. Through inclusivity, collaboration, and a dedication to integrity and accountability in our regulatory practices, we create an equitable environment that protects and prioritizes the public's best interests.

The mandate of the CPhM is to serve and protect the public interest

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

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Message from the Chair

Dear pharmacy professionals and members of the public,

This summer has been challenging for many people living in Manitoba due to the ongoing wildfire situation across the province. Through these difficulties, the College of Manitoba of Pharmacists (CPhM) remains committed to protecting the public's health and supporting displaced individuals through the continuation of pharmacy care.

Amid this uncertainty, I am honoured and excited to start my term as Chair on Council. I want to thank the past Chair, Ryan Buffie, for his commitment and leadership over the past year and his years of service on Council. It has been a privilege to work with him, and I look forward to building upon the strong foundation he and others have established.

I also want to thank all current and former members of Council for their contributions. Your dedication to safeguarding public health has not gone unnoticed. I welcome David Mullins and Todd Derendorf to Council and I look forward to working with them and the rest of Council. You can learn more about the 12 appointed Council members here: https://cphm.ca/about-the-college/council/council-members/.

Over the past few months, CPhM staff have been in the process of transitioning to the new office at 210 Commerce Drive, within the Center for Professional Regulatory Collaboration (CPRC). This is a shared space with other Manitoba health profession regulators, providing opportunities for increased collaboration and resource efficiency, while maintaining CPhM's independence.

Additionally, CPhM is working on several key projects to modernize and strengthen key areas of pharmacy regulation. Those who read CPhM's bi-weekly Friday Five updates will be familiar with two exciting projects that have begun, work on the Continuing Competency Program by Dr. Nancy Winslade, and work on developing an updated practice direction for hospital pharmacy by Dr. Katrina Mulherin. Both projects aim to streamline regulatory processes and better support pharmacy professionals in delivering quality care. I encourage everyone to stay informed through upcoming Friday Fives and newsletters, as these will include the latest updates and opportunities to contribute to the projects through consultation.

For more opportunities to get involved, I encourage pharmacy professionals and members of the public to consider volunteering to serve on a CPhM committee. These committees offer valuable opportunities to shape the future of pharmacy regulation. To learn more about getting involved, please visit https://cphm.ca/about-the-college/committees/.

Looking ahead, I am eager to collaborate with government, Council members, and committee volunteers to make progress on the key initiatives in the CPhM Strategic Plan. By working to strengthen the pharmacy workforce, prepare for regulatory changes, and enhancing operation systems, CPhM will continue to support the evolving needs of everyone accessing pharmacy care in Manitoba.

Sincerely,

Kathy Hunter

Feature Article: CPhM Hospital Standards and Guidelines (2004) Overhaul

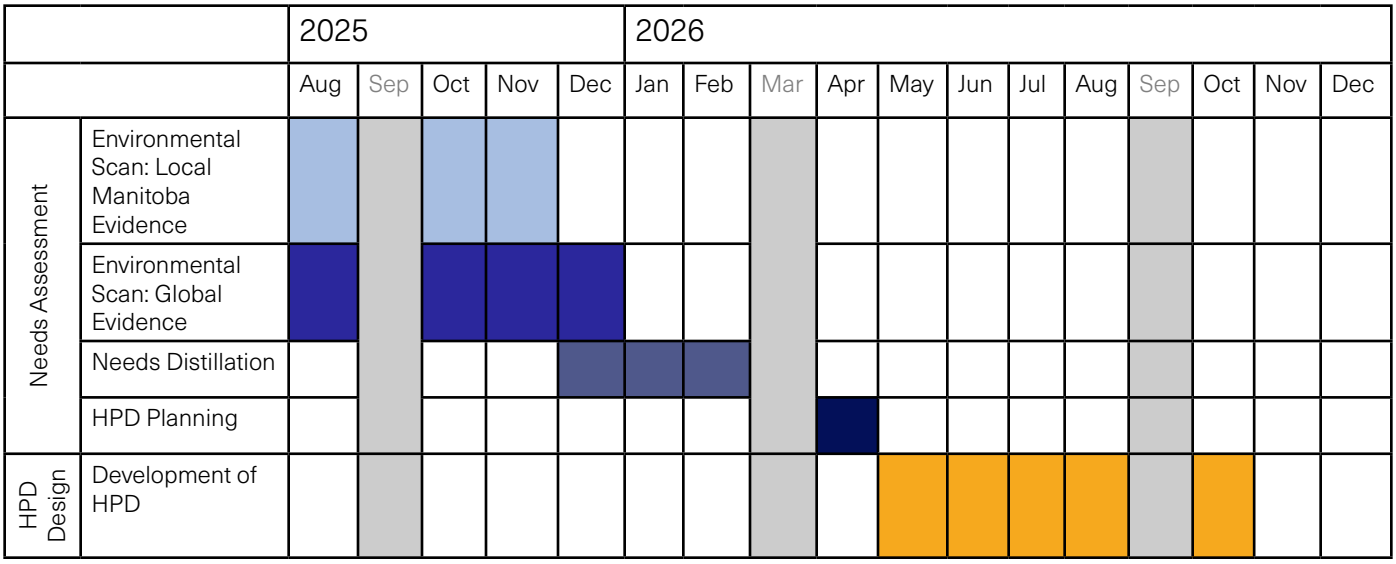
The College of Pharmacists of Manitoba (CPhM) is committed to producing new, evidence-based regulatory practice expectations through a Practice Direction for Hospital Pharmacy. An updated and modernised Hospital Practice Direction (HPD) ensures alignment with current standards, expectations and best practices, while reinforcing CPhM's mandate to protect the public through the delivery of safe, accessible and quality care. The HPD will replace the current Hospital Standards of Practice and Guidelines (approved in 2004).

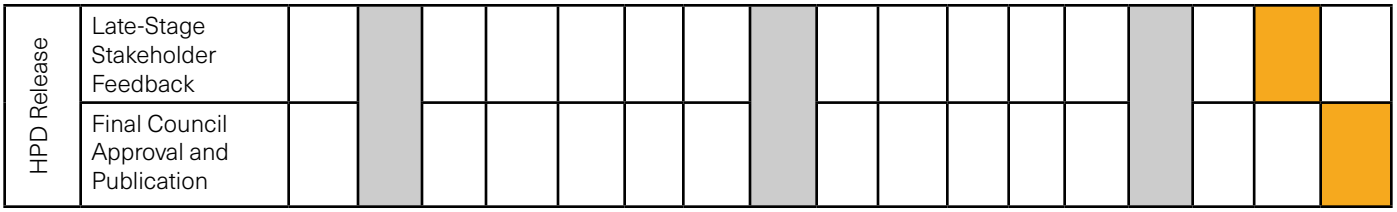
Hospital pharmacy practice differs from that of other settings in terms of patient acuity, interprofessional team-based care and medication provision processes. Hospital practice presents unique risks to quality and safety of patient care highlighting the need for hospital-specific guidance.

Hospital practice, similar to other pharmacy sectors has evolved dramatically over the last two decades. CPhM's regulatory frameworks, policy and programs have also evolved over the years. These co-evolutions combined with the outdated current Hospital Standards of Practice and Guidelines, necessitates a modernised HPD. CPhM has engaged Dr. Katrina Mulherin, BSc. Pharm, Pharm D of Windpharm Inc to lead the HPD Project. Dr. Mulherin brings strong clinical knowledge and regulatory experience to the role. Her background includes clinical pharmacy practice at Toronto's Sunnybrook Neonatal Intensive Care (NICU), as well as years of extensive regulatory experience as Deputy Registrar and Administrator of Complaints for the New Brunswick College of Pharmacists (NBCP). Her expertise in social, behavioural, and administrative pharmacy research, applied to regulatory policymaking, further supports this work.

Dr. Mulherin also brings her diverse skillset in several areas, including teaching and education, leadership, ethics, healthcare administrative law, behavioural economics, and occupational psychological health and wellness. This expertise allows her to think creatively about complexities of hospital pharmacy practice, pharmacy professionals, and the needs of their patients.

The HPD Project started in July 2025 and is scheduled to conclude at the end of 2026. The graphic below provides further detail of the phases and timeline.





CPhM's Professional Practice Committee (PPC) will meet with Dr. Mulherin to provide feedback and input over the course of this project. The Needs Assessment Phase is now underway. CPhM is collecting and analyzing local data related to hospital pharmacy practice, including risks to the public. Starting in October 2025, pharmacy professionals will have an opportunity to contribute to the Needs Assessment through an electronic questionnaire, followed by engagement with targeted focus groups. Contributions, insight and feedback are encouraged from all sectors including community, hospital and other practice settings, as well as from direct patient care providers and leadership roles. Perspectives from Manitoba healthcare leaders will be gathered to inform this regulatory practice direction.

Additional opportunities for dialog and targeted engagements will be confirmed and communicated in the coming months.

Personal experiences from pharmacy professionals are essential in shaping, a strong, responsive and updated HPD. By contributing your perspective, you support the quality and safety of pharmacy care, helping to improve health outcomes for all receiving care in Manitoba. CPhM looks forward to your involvement in the HPD Project.

Safety Feature: Starting Strong: Onboarding Your Team to Safety IQ

Safety IQ is designed to help pharmacies enhance patient safety through Continuous Quality Improvement (CQI). Here's how to successfully onboard your team to Safety IQ:

1. Introduce Safety IQ Early

Begin by explaining the importance of Safety IQ to your team right from the start. Make sure everyone understands the goal: improving patient safety by identifying and addressing medication incidents and near-miss events. Emphasize that Safety IQ is a priority for the entire team, not just a compliance requirement.

2. Clarify Roles and Responsibilities

Everyone in the pharmacy must understand their role in the Safety IQ process. Ensure your staff knows who is responsible for what tasks, such as reporting incidents, conducting Safety Self-Assessments (SSAs), or leading CQI meetings. Assigning any member of staff, including pharmacists, pharmacy technicians, and pharmacy assistants, as a CQI Coordinator can help keep things organized and improve accountability.

3. Provide Comprehensive Training

Training is essential for the success of Safety IQ. All staff, including pharmacists, pharmacy technicians, pharmacy assistants, and other pharmacy employees, must be trained on how to respond to an incident. Offer training materials, such as videos, guides, and CPhM resources, to help empower everyone with knowledge regarding medication safety and best practices

- For more resources on how to document and analyze incidents visit https://safetyiq.academy/.

4. Encourage Open Communication

Foster an environment of trust where staff feel comfortable reporting medication errors and near-misses without fear of blame. Regular discussions, like team meetings or safety huddles, should encourage sharing experiences and suggestions for improvement. A transparent approach builds a positive and lasting safety culture.

5. Align Safety Goals with Pharmacy Objectives

Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy. Here are the latest posts:

- Collecting Critical Patient Information: Key to Preventing Medication Incidents

  Guest Author Eunice Valencia is a PGY-1 pharmacy resident at the Winnipeg Regional Health Authority. She received her Doctorate of Pharmacy (PharmD) from the University of Manitoba in 2024. Her residency experiences have provided her with a strong foundation in clinical practice, and she is passionate about identifying and developing strategies to optimize patient care and promote patient safety. t safety.

- Developing an Effective Training Plan for New Pharmacy Staff: A Key to Patient Safety and Workplace Success

  A thoughtful training plan helps new pharmacy staff gain confidence, improve workflow efficiency, and enhance patient safety. Discover four practical steps to develop an effective onboarding process that supports both employees and the pharmacy team.

Make patient safety a core part of your pharmacy's mission. By aligning patient safety with your broader pharmacy objectives, your team will be more engaged and invested in reducing medication errors and enhancing care.

With these strategies, you can create a proactive safety culture that benefits both your team and your patients.

Resources for Professional Development

Safety Measure

Data Repository Safety Brief from the NIDR

Data matters! Statistical reports from the National Incident Data Repository (NIDR) for Community Pharmacies highlight the common types of incidents and near-miss events in Manitoba, guiding the improvement efforts of pharmacy professionals and the College of Pharmacists of Manitoba (CPhM).

Here is a summary of the data reported by Manitoba's pharmacy professionals from October 1, 2024 to March 31, 2025:

- Pharmacy professionals have submitted 1348 reports to the NIDR
- Pharmacy professionals have reported 1145 medication incidents (medication dispensed and reached the patient) and 103 caused patient harm
- Pharmacy professionals reported 369 near-miss events

The top three incident types were:

- Incorrect drug
- Incorrect dose/frequency
- Incorrect quantity

Please view the Safety IQ: 2024 Year in Review graphic for more details.

DISCIPLINE DECISIONS/SUSPENSIONS

Decision and Order of the Discipline Committee: Hajra Mirza

Pursuant to a Notice of Hearing dated January 8, 2020, an Amended Notice of Hearing dated January 2020, a Notice of Hearing dated August 17, 2020, an Amended Notice of Hearing dated August 2020, and a Notice of Hearing dated March 10, 2021 (the "Notices") a hearing was convened by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the offices of Thompson Dorfman Sweatman LLP, 242 Hargrave Street, Suite #17, Winnipeg, Manitoba, R3C 0V1, on December 11, 2023 and December 12, 2023, with respect to charges formulated by the College alleging that Hajra Mirza ("Mirza"), 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 Rossmere Pharmacy, (the "Pharmacy"), Unit D - 1046 Henderson Highway, in Winnipeg, Manitoba, Mirza:

- **See the Notices attached hereto as Schedule "A"**

The hearing into the charges convened on December 11, 2023. Mr. Jeffrey Hirsch ("Mr. Hirsch") and Ms. Sharyne Hamm ("Ms. Hamm") appeared as counsel on behalf of the Complaints Committee. Mirza appeared unrepresented by counsel. Mr. Joseph A. Pollock ("Mr. Pollock") appeared as counsel to the Discipline Committee (the "Panel").

A Statement of Agreed Facts (the "Statement") was filed in which Mirza admitted:

1. her membership in the College.

2. valid service of the Notices that the College complied with the requirements of sub-sections 46(2) and 46(3) of the Act.

3. she 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. she graduated with her pharmacy degree from an institution in the United States of America in 2009.

5. she was licensed as a pharmacist in British Columbia from June 2009 to August 2013. She had one discipline outcome in B.C. on June 12, 2012, and was suspended for a period of one month from June 25, 2012, to July 25, 2012.

6. she was licensed as a pharmacist in Manitoba between October 15, 2013 and June 24, 2019.

7. in May 2016, she became the pharmacy manager of the Pharmacy.

8. as of September 8, 2016, she was a 50% owner in the Pharmacy.

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

10. [redacted]

11. [redacted]

12. she voluntarily surrendered her license on June 25, 2019.

13. she has reviewed the Notices, as well as this Statement of Agreed Facts. She admits 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 submitted, be substantially in accordance with these facts.

The Complaints Committee entered a stay of counts 27 and 30 as set out in the Amended January 2020 Notice.

Mirza entered a plea of guilty to counts 1-26, 28 and 29 as set out in the Amended January 2020 Notice.

The Complaints Committee entered a stay of count 11 as set out in the Amended August 2020 Notice.

Mirza entered a plea of guilty to counts 1-10 as set out in the Amended August 2020 Notice. The Complaints Committee entered a stay of count 2 as set out in the March 2021 Notice.

Ms. Mirza entered a plea of guilty to count 1 as set out in the March 2021 Notice. Notice.

In the Statement, pertaining to Notices, the parties agreed that:

The Amended January 2020 Notice

1. On June 21, 2019, the College received a police report with respect to Mirza, which alleged that Mirza had left unlabelled drugs in an unmarked bag with an employee at a Dairy Queen restaurant for a patient's [redacted] to retrieve.

2. On June 21, 2019, Ms. Susan Lessard-Friesen, then-Registrar of the College (the "Registrar"), made a referral to the College's Complaints Committee (the "Committee").

3. Mirza met with the Committee on June 24, 2019.

4. On June 24, 2019, Mirza voluntarily surrendered her license and resigned as pharmacy manager of the Pharmacy (the "Voluntary Surrender").

5. On June 25, 2019, Ms. Rani Chatterjee-Mehta, then-Assistant Registrar - Quality Assurance for the College, wrote to Mirza to remind her of her obligation not to practice pharmacy while her

license was surrendered.

6. On or about June 24, 2019, the Committee ordered an investigation and the Registrar appointed Mr. Ken Zink, as the investigator to conduct the investigation (the "Investigator").

7. The Investigator conducted interviews with Dairy Queen staff members on July 11 and July 12, 2019.

8. On July 12, 2019, the Investigator conducted a site visit at the Pharmacy. This site visit revealed issues with narcotic accountability, frequent and high dose opioid dispensing and other administrative and security issues. Subsequent site visits to the Pharmacy occurred on July 24 and July 31, 2019.

9. On July 18, 2019, the Investigator conducted a telephone interview with patient [redacted]

10. The Investigator interviewed Mirza on August 13, 2019, and August 21, 2019.

11. The Investigator submitted his Investigation Report to the Committee on October 9, 2019.

12. The Investigator submitted a Supplemental Investigation Report to the Committee on January 3, 2020.

13. On or about November 27, 2019, the Committee referred the matter to the College's Discipline Committee.

14. On January 7, 2020, the Registrar wrote to Mirza to advise her that she must cease and desist the practice of pharmacy, as her license remained voluntarily surrendered. The January 2020 Notice was issued on January 8, 2020.

Count 1 (a) through (h)

15. On or about Friday, June 14, 2019, Mirza was contacted by patient,[redacted] regarding pain and fever-like symptoms following a recent dental surgery.

16. On or about Saturday, June 15, 2019, . again contacted Mirza with respect to [redacted] symptoms. Mirza advised [redacted] to contact [redacted] a Nurse Practitioner ("NP") who then prescribed 56 Tylenol #3® with codeine and 14 naproxen 500 mg, as well as 28 clindamycin 300mg for [redacted]

17. The prescriptions were faxed to the Pharmacy, which was closed at that time. Mirza then drove to the Pharmacy, bottled some of the medication for [redacted], and left these unlabelled drugs in an unmarked bag with an employee at a nearby DQ restaurant for the [redacted] of [redacted] to pick up.

18. Upon her attendance at the DQ, Mirza handed the unlabelled bag of medications to a young employee of the DQ. She did not confirm the name of the DQ staff member nor did she make any attempt to confirm that the staff member was familiar with patient [redacted]

19. After leaving the DQ, Mirza texted [redacted] t 9:14 p.m. informing [redacted] that "[redacted] meds done and delivered."

20. [redacted] arrived to pick up the medications, but the DQ owners would not release the medications to [redacted]. According to the police report, the WPS was contacted at 9:24 p.m. and the patrol car

that responded was dispatched at 10:07 p.m. Mirza returned to the DQ, and the police escorted her to the Pharmacy, where the medications were labelled. The police then delivered the medications to [redacted] at 10:46 p.m.

21. Constable [redacted] of the Winnipeg Police Service ("WPS") confirmed to the Investigator via email on July 31, 2019, that:
    a. Upon returning to the Pharmacy with Mirza on June 15, 2019, Mirza completed the prescription labels for the medication, and affixed them to the bottles;
    b. The WPS obtained the names and quantities of the medication contained within the bottles from the labels affixed by Mirza when she was escorted to the Pharmacy;
    c. After the prescriptions were properly labelled, they appeared to be the same as those that were left at the DQ; and
    d. The photo taken by DQ staff, was an accurate depiction of the medication seized at the DQ on the night of June 15, 2019.

22. Subsection 2.3.1 of the DDS PD requires a pharmacy manager to ensure that all drugs are secured against theft, loss, or diversion. Subsection 2.6 of the DDS PD further requires that if a drug is to be picked up at a location that is not a licensed pharmacy, the location must be under the control of a trustee (as defined in *The Personal Health Information Act* C.C.S.M. c. P33.5 ("PHIA") as a health professional, health care facility, public body, or health services agency that collects or maintains personal health information) or as described in the Delegation PD.

23. Section 43 of the NCRs also requires pharmacists to take reasonable steps to protect narcotics from loss or theft. Acetaminophen with codeine 30mg is a narcotic drug.

24. Mirza's actions contravene the requirement to ensure that all drugs are secured against theft, loss or diversion, and Mirza's obligations under Statement VII of the Code to hold the safety of each patient to be of primary consideration.

25. Subsection C.01.005(1) of the FDRs require that all drugs be labelled to show the drug identification number. If the drug is a narcotic, subsections C.01.005.1(a) and (b) of the FDRs require that the drug packaging must have a warning sticker and a patient info1mation handout specific to the narcotic being sold.

26. Subsection 71(1) of the Regulation requires that drugs not be dispensed unless the container in which it is dispensed is properly labelled.

27. Mirza did not apply prescription labels to the three prescription bottles left at the DQ, at the request of [redacted] There was no patient info1mation handout contained with the unlabelled package.

28. Constable [redacted] upon escorting Mirza back to the Pha1macy, insisted that she apply labels to the medication bottles herself, and she did so. One of the bottles was labelled "Tylenol with Codeine" by Mirza.

29. By failing at first instance to apply labels to the medication, Mirza contravened subsections C.01.005(1), C.01.005(a) and (b) of the FDRs, as well as subsection 71(1) of the Regulation.

30. Subsection 70(1) of the Regulation requires that drugs not be dispensed unless a prescription record is made. In addition, subsections 38 and 40 of the NCRs, require that where a pharmacist dispenses a narcotic, they must immediately enter into a book, register or other record certain

info1mation including the patient's name, practitioner's name, and the name, form and quantity of the narcotic, among other things. The NCRs require that the pharmacist maintain a special narcotic prescription file for all narcotics they have dispensed in accordance with a verbal order or prescription.

31. The prescriptions for naproxen and clindamycin were not entered into the Pharmacy's computer until 10:30 p.m., and the acetaminophen with codeine was not entered until 10:31 p.m. This was after the WPS attended at the Pharmacy with Mirza.

32. Failing to enter the prescriptions properly put patient safety at risk. Mirza missed an allergy warning on [redacted]'s patient screen that [redacted] had previously had a negative reaction to clindamycin. In addition, as the Pharmacy was closed the following day, no record would have been entered into the DPIN for multiple days, meaning that other health care providers would not have been aware of the provision of these drugs by reviewing the DPIN record.

Count 26

33. There was neither a patient name label nor a business card attached to the exterior of the bag left at the DQ.

34. There was no signed document predating June 15, 2019, from patient [redacted] in which [redacted] had requested that [redacted] medications never be labelled.

35. The photo taken by DQ staff shows three vials of medication. The vial on the right is clindamycin 300mg, and the tablets on the left match the appearance of naproxen EC 250mg tablets. The centre bottle contains round white tablets, and the only products f01md to be stocked at the Pharmacy that match the tablets in the photo is Tylenol #3® or Ratio-Lenoltec 30®, both of which are narcotic drugs.

Count 2 (a)

36. Mirza delegated responsibility for narcotic accountability procedures to [redacted] a pharmacy assistant. [redacted] supervised the counts.

Count 2 (b)

37. Adjacent to the dispensary at the Pharmacy is a room identified as the “Counselling Room”. This room contained a large narcotic safe, prescription files stacked almost to the ceiling, pharmacy documentation such as narcotic invoices, completed bubble packs, completed prescriptions waiting to be picked up, and personal staff items. The room was utilized for patient consultations and the administration of vaccines and injections. The utilization of this counselling room in this manner put the confidentiality of patient information at risk, as the exterior labels of many prescription bags were found to contain confidential health information.

Count 2 (c) and (d)

38. The perpetual inventory systems in place at the Pharmacy were twofold: a computerized system and a manual perpetual inventory book. The computerized system could not determine the on-hand quantity of a drug. Some stated quantities varied by hundreds of tablets, either over what was expected or short by similar amounts. The reasons for this inaccuracy included faulty receiving procedures, as well as a failure to reset computer quantities with counted on-hand

amounts.

39. The manual perpetual inventory logbook also could not function as a perpetual inventory. For most drugs, this logbook was merely a listing of transactions. Filled prescription records and drug receiving entries were listed, albeit often many days or weeks late and there was no means by which pharmacy staff could determine the on-hand quantity of a drug or investigate a dispensing error.

40. Some of the more commonly dispensed drugs were counted and compared to the manual perpetual inventory book and the computerized tally, with the following results:

DRUG	MANUAL INVENTORY	COMPUTERIZED INVENTORY	PHYSICAL COUNT
Apo-oxycodone® CR 80mg	376	(4103) negative	242
Apo-oxycodone® CR 40mg	268	(1201) negative	336
Oxyneo® 80mg	56	(382) negative	64
Oxyneo® 40mg	175	(205) negative	132
Oxyneo® 60mg	106	(176) negative	64
Supeudol® 20mg	116	(51) negative	102

41. The issue with the perpetual inventory system was previously raised by the College inspection report of the Pharmacy of December 11, 2017. On January 16, 2018, Mirza indicated to the College that she had become compliant in maintaining a perpetual inventory.

42. No perpetual inventory was maintained for non-reportable controlled drugs or benzodiazepines.

43. Due to the failure to maintain an accurate perpetual inventory for narcotic and controlled substances, the Pharmacy was unable to accurately determine whether there were any discrepancies between dispensed quantities and controlled substances sales reports.

Count 2(e)

44. Regular manual inventory counts of controlled substances were not regularly completed at the Pharmacy. When these counts were completed, they were flawed and did not provide an accurate comparison of expected vs actual on-hand quantities.

45. From the time the Pharmacy opened in 2016, it would be expected that 12 quarterly narcotic counts would have been completed. The records indicate only four narcotic counts, on July 25, 2018, October 25, 2018, March 10, 2019 and July 7, 2019.

46. There is no documentation of any physical counts being done for benzodiazepine or other targeted substances.

Count 2 (f) and (g)

47. The four narcotic counts that had been completed at the Pharmacy since September of 2016 revealed that there were significant unexplained drug shortages.

48. Mirza never reported any of these discrepancies to either Health Canada OCS or to the College.

Count 2 (h)

49. There is no documentation to show that expired, damaged, or patient returned narcotic and controlled drugs were accounted for within the inventory system, nor were there any regular physical counts done or documented for these drugs.

Count 2 (i) and (j)

50. In July 2019, and September 2019, Mirza could not produce narcotic purchase records and select prescription files for the period prior to April 1, 2019.

Count 2 (k)

51. Outdated and patient returned narcotic and controlled drugs awaiting destruction were kept in a small box in a dispensary cupboard. There were no associated inventory logs of these drugs, nor any listing of the quantity, name or date received.

52. The only documentation present was the destruction logs, which followed a College template. The drug name, strength, quantity and whether the drug was expired or a patient return was filled out, but no date of destruction was provided. There was also no signature or any indication that a pharmacy manager was involved in the destruction. The only signature or initials belonged to [redacted], who is described as the manager at the [redacted], a clinic that is adjacent to the Pharmacy. [redacted] has no formal health care training.

53. There is no evidence that the destruction of these narcotic and controlled drugs was carried out by anyone other than [redacted], who is an administrator and not a health care professional.

Count 2 (l)

54. The Facilities PD requires:
    a. that the dispensary only be accessible to authorized personnel;
    b. that the dispensary have secure drug storage; and
    c. that patient information be kept securely, including during patient counselling, to protect the patient's right to privacy.

55. Adjacent to the dispensary at the Pharmacy is a room identified as the "Counselling Room". This room contains a large narcotic safe, prescription files stacked almost to the ceiling, pharmacy documentation such as narcotic invoices, completed bubble packs, completed prescriptions waiting to be picked up, and personal staff items. The room was utilized for patient consultations and the administration of vaccines and injections. Completed prescriptions were not appropriately stored.

56. During three unannounced site visits to the Pharmacy, the large narcotic safe located in the patient counselling room was left unlocked and with the door left open. There was also a second entrance to the counselling room from the medical office hallway which led to the rear exit and which was left unlocked and open on all occasions. Anyone entering the back door from the parking lot of the building had a view of the interior of the narcotic safe with nothing to stop them from accessing narcotic storage.

Count 3

57. The Pharmacy regularly dispensed a large number of opioid prescriptions for many patients, some at very high doses. The majority of patients were under the care of nurse practitioner, [redacted] who worked out of an office adjacent to the Pharmacy.

58. The dispensing histories of 14 of 18 patients using high dose opioid drugs were found to be at either the same, or higher, doses from when they began treatment [redacted]

59. The Guideline recommends a dosage of not more than 90mg MEQ/day as a watchful dose of opioids, where the balance between benefits and harm often becomes unfavourable. When the use of a medication or its dosage is outside of standard practice, there is a risk of serious harm to the patient. In such circumstances, pharmacists should include documentation with each dispensation that records:
    a. Counselling points provided to the patient related to safety;
    b. Discussion with the patient of any adverse effects experienced;
    c. Determination with the patient if the goals of therapy are being met;
    d. Any early refill requests;
    e. Upon an initial concern and when new or repeated concerns arise, discussion with the prescriber about concerns related to lack of benefit and/or potential for harm, appropriate tapering plan options, considerations for referral as appropriate and the prescriber's subsequent response; and
    f. The pharmacist's plan for follow up.

60. In addition, when communicating concerns with the prescriber as required, the discussion ought to include clarification of the dose, current standards of practice or Guideline recommendations, the specific safety implications, options for the best course of action, and the pharmacist's recommendation based on the discussion.

61. Section 78 of the Act states that pharmacists may not, in dispensing a drug pursuant to a prescription, substitute one drug for another or one brand of drug for another, without the consent of the prescriber.

62. Subsection 78(1)(b) of the Regulation requires that a pharmacist take reasonable steps to ensure patient safety when dispensing opioids. Subsection 83 of the Regulation states that ensuring patient safety includes consideration of the appropriateness of the drug therapy, therapeutic duplication, ensuring the correct dosage, frequency and duration of administration is being provided, and ensuring that the drug prescribed is consistent with standards of care and patient safety.

63. Sections 2.2, 2.3 and 2.4 of the EPS PD require pharmacists to assess whether there is an actual or potential risk to patient safety specific to the patient and the drug therapy and, where identified, take appropriate action to address the problem by collaborating with the patient and the prescriber.

64. Recommendations 9 and 10 within the Guideline suggest tapering opioids to the lowest effective dose for patients with non-cancer pain and who are using 90mg MEQ/day of opioids. If the patient is having serious challenges in tapering, a formal multidisciplinary program is recommended.

65. Statements I, II, VII and IX of the Code require pharmacists to maintain a high standard of

professional competence, cooperate with colleagues and other health care professionals to ensure optimal patient-centered care and hold the health and safety of each patient to be of primary consideration.

66. Patient [redacted], began receiving opioid prescriptions at the Pharmacy in or around October 2017. At that time, [redacted] dose was equivalent to 600mg MEQ/day.

67. As recently as June 11, 2019, [redacted] had received dosages equivalent to 1200mg MEQ/day, an increase of +600mg MEQ/day over the initial treatments.

68. There is no documentation to show that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]'s high dose of opioids. Mirza admits that she did not meet her professional obligations in having and documenting conversations with [redacted]'s prescribers about the dosages provided to [redacted] between October 2017 and June 2019.

69. [redacted] was prescribed 196 Oxycontin 80mg, to be taken as two tablets three times per day, with provision for one extra tablet if [redacted] was experiencing severe pain, to be dispensed as 98 tablets every 14 days starting Friday, December 29, 2017.

70. 70. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

71. On December 28, 2017, Mirza dispensed 98 tablets to [redacted] This fill was one day early with no explanation documented or provided for the early fill.

72. On January 8, 2018, Mirza dispensed 98 tablets to [redacted] This fill was provided four days early with no explanation documented and no evidence of consultation with the prescriber.

Count 4

73. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around October 2018. At that time, [redacted]s dose was equivalent to 360mg MEQ/day.

74. As recently as July 18, 2019, [redacted]. had received dosages equivalent to 600mg MEQ/day, an increase of +240mg MEQ/day over the initial treatments.

75. There is no documentation to show that Mirza had been collaborating with prescribers to work towards a taper of patien[redacted]s high dose of opioids. Mirza admits that she did not meet her professional obligations in having and documenting conversations with [redacted] prescribers about the dosages provided to [redacted]. between October 2018 and February 2019.

76. [redacted] was prescribed 210 Oxycontin 80mg, to be taken as two tablets every 12 hours, to be dispensed as 35 tablets every seven days.

77. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made effo1ts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

78. On December 31, 2018, Mirza dispensed 35 tablets to [redacted]. On January 5, 2019, Mirza dispensed 35 tablets to [redacted]. There were no notes or explanations as to why the prescription was refilled two days early. There was no indication that Mirza consulted the prescriber with respect to the early fill. This conduct is a breach of the authorities referred to in Count 4 above.

Count 5

79. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around February 2018. At that time,[redacted] dose was equivalent to 840mg MEQ/day.

80. As recently as March 15, 2019, [redacted] had received dosages equivalent to 930mg MEQ/day, an increase of +90mg MEQ/day over the initial treatments.

81. There is no documentation to show that Mirza had been collaborating with prescribers to work towards a taper of patien[redacted] high dose of opioids. Mirza admits that she did not meet her professional obligations in having and documenting conversations with[redacted]s prescribers about the dosages provided to [redacted] between February 25, 2019 and March 15, 2019.

82. [redacted] was prescribed 224 Oxycontin 80mg, to be taken as eight tablets every day, to be dispensed as 56 tablets every seven days.

83. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

84. On February 28, 2019, Mirza dispensed 56 Oxycodone 80mg tablets to[redacted] , then on March 6, 2019, another 56 tablets. On March 11, 2019, Mirza. again dispensed 56 tablets to [redacted] There were no notes or explanations as to why the prescription was refilled two days early on March 11, 2019. There was no indication that Mirza consulted the prescriber with respect to the early fill. This conduct is a breach of subsection 69(4) of the Regulation.

85. On March 15, 2019, Mirza dispensed 56 tablets Oxycodone 80mg to [redacted] There were no notes or explanations as to why the prescription was refilled five days early. There was no indication that Mirza consulted the prescriber with respect to the early fill.

86. [redacted] was prescribed 84 oxycodone IR 20mg, to be taken as one tablet three times per day if needed, to be dispensed as 21 tablets eve1y seven days.

87. On February 28, 2019, Mirza dispensed 21 oxycodone IR 20 mg tablets to [redacted] then on March 6, 2019, another 21 tablets. On March 11, 2019, Mirza dispensed 21 tablets t[redacted]. There were no notes or explanations as to why the prescription was refilled two days early. There was no indication that Mirza consulted the prescriber with respect to the early fill.

88. On March 15, 2019, Mirza dispensed 21 oxycodone IR 20 mg tablets to[redacted]. There were no notes or explanations as to why the prescription was refilled five days early. There was no indication that Mirza consulted the prescriber with respect to the early fill.

Count 6

89. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around August 2018. At

that time [redacted] dose was equivalent to 510mg MEQ/day.

90. As recently as July 18, 2019, [redacted] had received dosages equivalent to 645mg MEQ/day, an increase of+ 135 MEQ/day over the initial dosages.

91. There was no documentation showing that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]'s high dose of opioids. Mirza admits that she did not meet her professional obligations in having and documenting conversations with [redacted] prescribers about the dosages provided to [redacted] between August 2018 and July 2019.

92. On August 7, 2018, [redacted] was prescribed 112 Oxycontin 80mg, to be taken as one tablet fom times per day, to be dispensed as 28 tablets eve1y seven days.

93. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made effo11s to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

94. On August 7, 2018, Mirza dispensed 28 tablets to [redacted]

95. On August 10, 2018, the prescriber authorized an early release of 28 tablets with the condition the next fill was to be done on August 21, 2018, and no sooner.

96. On August 14, 2018, Mirza dispensed 28 tablets. There was no documentation of conversation with the prescriber authorizing this fill seven days early.

97. Mirza dispensed 28 tablets to [redacted] on August 22, 2018. There was no documentation of conversation with the prescriber authorizing this fill six days early.

98. On August 7, 2018, [redacted]. was prescribed 112 oxycodone 5/325, to be taken as one tablet four times per day, to be dispensed as 28 tablets every seven days. On August 7, 2018, Mirza dispensed 28 tablets to [redacted]

99. On August 10, 2018, the prescriber authorized an early release of 28 tablets with the condition the next fill was to be done on August 21, 2018, and no sooner.

100. On August 14, 2018, Mirza dispensed 28 tablets. There was no documentation of conversation with the prescriber authorizing this fill seven days early.

101. Mirza dispensed 28 tablets to [redacted] on August 22, 2018. There was no documentation of conversation with the prescriber authorizing this fill six days early.

102. On January 22, 2019, [redacted] was prescribed 150 Oxycontin 80mg, to be taken as five tablets daily, to be dispensed twice weekly, no more than 35 per week.

103. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

104. On January 29, 2019, Mirza dispensed 20 tablets of oxycodone 80 mg to [redacted] There was no

computerized nor written explanation for the extra five tablets, or evidence of any consultation with the prescriber.

105. On January 30, 2019, Mirza dispensed 20 tablets of oxycodone 80 mg to [redacted] This was an early fill. The prescriber sent an email releasing five days of medication to last until February 5, 2019. Together with a fill provided on February 2, 2019, [redacted] was provided with eight days of medication.

106. On January 22, 2019, [redacted] was prescribed 180 oxycodone 5/325, to be taken as six tablets daily, to be dispensed twice weekly, no more than 42 per week. On January 29, 2019, Mirza dispensed 24 tablets of oxycodone 5/325 to [redacted] an over-fill of nine tablets. There was no computerized nor written explanation for the extra nine tablets, or evidence of any consultation with the prescriber.

107. On January 30, 2019, Mirza dispensed 24 tablets of oxycodone 5/325 to [redacted]. This was an early fill., contrary to the prescriber's directions. The prescriber sent an email releasing five days of medication to last until February 5, 2019. Together with a fill provided on February 2, 2019, [redacted] was provided with eight days of medication.

108. The conduct described in paragraphs 89-107 above constitutes a breach of the authorities referred to in Count 6 above.

Count 7

109. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around July 2018. At that time, [redacted] dose was equivalent to 960mg MEQ/day.

110. As recently as July 18, 2019, [redacted] had received dosages equivalent to 960mg MEQ/day, with no change over the initial dosages.

111. The Investigator did not locate any documentation or evidence that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]'s high dose of opioids. Mirza admits that she did not meet her professional obligations in having and documenting conversations with [redacted]'s prescribers about the dosages provided to [redacted]. between July 2018 and July 2019.

112. On April 30, 2019, [redacted] was prescribed 224 Oxycontin 80mg, to be taken as two tablets four times per day with a maximum of eight per day, to be dispensed as 56 tablets every seven days.

113. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

114. On May 2, 2019, Mirza dispensed 56 tablets to [redacted]

115. On May 8, 2019, the Pharmacy dispensed 56 tablets to [redacted] There were no notes or explanation as to why the prescription was refilled one day early.

116. On May 15, 2019, the Pharmacy dispensed 56 tablets to [redacted] There were no notes or explanation as to why the prescription was refilled one day early.

117. On May 21, 2019, Mirza dispensed 56 tablets to [redacted] There were no notes or explanation as to

why the prescription was refilled two days early.

118. On January 12, 2019, [redacted] was prescribed 336 Oxycodone 80mg, to be taken as two tablets four times per day, to be dispensed as 112 tablets every 14 days. On January 12, 2019, Mirza dispensed an initial fill of the Oxycodone 80mg prescription.

119. On January 23, 2019, Mirza dispensed 112 tablets to patient [redacted] There were no notes or explanation as to why the fill was provided three days early.

120. On February 2, 2019, the Pharmacy dispensed 112 tablets to patient [redacted] There were no notes or explanation as to why the fill was provided seven days early.

121. The conduct described in paragraphs 109-120 above constitutes a breach of the authorities referred to in Count 7 above.

Count 8

122. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around April 30, 2019. Around October 2019, [redacted]s dose was equivalent to 1200mg MEQ/day.

123. As recently as July 17, 2019, [redacted] had received dosages equivalent to 900mg MEQ/day, a decrease of -300mg MEQ/day over the initial dosages.

124. The Investigator did not locate any documentation or evidence that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted] high dose of opioids.

125. On April 30, 2019, patient [redacted] was prescribed 240 Oxycontin 80mg, to be taken as one to two tablets four times per day and dispensed on a daily basis with instructions to fill a maximum of eight tablets daily, with the option of providing a two-day supply if required. This allowed the Pharmacy to dispense to [redacted] to cover a weekend, as the Pharmacy was closed on Sundays.

126. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

127. On April 30, 2019, Mirza dispensed 24 tablets to [redacted] A note on the file indicates that [redacted] hurt [redacted] back so was given eight additional tablets for April 29 with prescriber approval.

128. On May 1, 2019, Mirza dispensed eight tablets to [redacted] as an early fill. There were no notes or explanation of why this fill was allowed.

129. On May 2, 2019, Mirza dispensed 16 tablets to [redacted] as an early fill. There were no notes or explanation of why this fill was allowed or why the quantity was doubled.

130. On May 3, 2019, Mirza dispensed 16 tablets to [redacted] as an early fill. There were no notes or explanation of why this fill was allowed or why the quantity was doubled.

131. On May 6, 2019, the Pharmacy dispensed 16 tablets to [redacted] as an early fill. There were no notes or explanation of why this fill was allowed or why the quantity was doubled. There was a note added to the computer profile for [redacted], reminding staff that the prescription was a daily dispense

prescription and noting that the patient could only pick up two days' supply "once in a while.".

132. On May 7, 2019, Mirza dispensed 16 tablets to [redacted] as an early fill. There was a screenshot of an incomplete text message attached to the hard copy prescription indicating that the patient was going on a road trip, but there is no documentation of conversation with the prescriber.

133. On May 8, 2019, Mirza dispensed 24 tablets to [redacted] as an early fill. There were no notes or explanation of why this fill was allowed or why the quantity was tripled.

134. Mirza provided a three-day supply to patient [redacted] on the very first fill, and also subsequent part fills of multiple two and three-day supplies. By the ninth day, [redacted] was a full six days ahead of schedule, meaning that [redacted] was dispensed an average of over 13 tablets per day. This equates to a daily dose of 1600mg MEQ/day. There was no computerized nor written documentation to explain why the prescriber's orders were not followed.

Count 9

135. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around July 2017. At that time, [redacted] dose was equivalent to 840mg MEQ/day.

136. As recently as July 5, 2019, [redacted] had received dosages equivalent to 770mg MEQ/day, a decrease of -70mg MEQ/day over the initial dosages.

137. There was no documentation to show that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted] high dose of opioids. Mirza admits that she did not meet her professional obligations in having and docun1enting conversations with [redacted] prescribers about the dosages provided to [redacted] between July 2017 and July 2019.

138. On April 5, 2019, patient [redacted] was prescribed 540 Oxycontin 80mg, to be taken as two tablets three times per day to a maximum of six per day, to be dispensed as 180 tablets every 30 days.

139. On April 5, 2019, Mirza dispensed 20 tablets to patient [redacted] There is a note on the prescription that the patient was cautioned but contained no details about what [redacted] was cautioned about.

140. Oxycontin, a discontinued product, has no interchangeable equivalent. Mirza substituted generic oxycodone CR 80mg without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

141. On April 8, 2019, the Pharmacy dispensed 50 tablets to [redacted]

142. On April 13, 2019, Mirza dispensed 50 tablets to [redacted]

143. On April 20, 2019, Mirza dispensed 70 tablets to [redacted]. This part fill exceeded the prescriber interval by 10 tablets. There were no notes or explanation of why this partial fill was allowed.

144. On April 22, 2019, the Pharmacy dispensed an additional 100 tablets to [redacted]. The amount of Oxycontin 80mg dispensed to the patient now exceeded the prescriber interval by 110 tablets. There were no notes or explanation of why this part fill was allowed.

145. On May 7, 2019, Mirza dispensed an additional 100 tablets to [redacted]. The amount of Oxycontin

80mg dispensed to the patient now exceeded the prescriber interval by 30 tablets. There were no notes or explanation of why this part filled was allowed.

146. On May 27, 2019, Mirza dispensed an additional 100 tablets to [redacted]. The amount of Oxycontin 80mg dispensed to the patient now exceeded the prescriber interval by 130 tablets. There were no notes or explanation of why this partial fill was allowed.

147. Within the first 30 days, patient [redacted] had already received 290 tablets exceeding the prescriber's directions by 110 tablets, and by the time the last part fill was due the patient had been issued 490 tablets, exceeding the prescriber's directions by 130 tablets. No documentation existed on either the prescription hard copies or the patient computer profile to explain the release of the early part fills.

148. By failing to hold the patient to proper fill dates the actual realized MEQ for patient [redacted] is 1278mg MEQ/day, which exceeded the prescriber's directions by 558 mg MEQ/day.

149. The conduct described in paragraphs 135-148 above constitutes a breach of the authorities referred to in Count 9 above.

Count 10

150. Patient [redacted] began receiving opioid prescriptions at the Pharmacy in or around July 2018. At that time, [redacted]'s dose was equivalent to 45mg MEQ/day, below the dosage recommended by the Guideline.

151. On April 16, 2019, patient [redacted] was also prescribed 84 OxyNeo® 80mg, to be taken as one tablet three times per day, to be dispensed 42 tablets every 14 days. On or about April 16, 2019, the Pharmacy dispensed the original prescription to patient [redacted] for a total of 42 tablets. 152.

152. On or about April 22, 2019, the Pharmacy dispensed 42 tablets to [redacted]. The prescription was refilled eight days early. There was no documentation, explanation or evidence of prescriber consultation, as well as no documentation present on either the prescription hard copies or the patient computer history to explain why the early fills were allowed to occur, why the quantity was altered, and whose decision it was to do so.

153. As recently as May 9, 2019, [redacted] had received dosages equivalent to 478mg MEQ/day, an increase of +433mg MEQ/day over the initial dosages.

154. There was no documentation to show that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted] high dose of opioids.

155. On May 9, 2019, patient [redacted] was prescribed 84 OxyNeo® 80mg, to be taken as one tablet every eight hours, to be dispensed 21 tablets every seven days.

156. On or about May 9, 2019, Mirza dispensed the original prescription to patient [redacted] for a total of 21 tablets.

157. On or about May 15, 2019, the Pharmacy dispensed 42 tablets to [redacted]. The quantity of the prescription was doubled. The prescription was refilled one day early and the quantity of the prescription was doubled without any explanation or evidence of consultation with the prescriber.

158. On May 27, 2019, Mirza filled the balance of this prescription three days early without any documented explanation or evidence of consultation with the prescriber.

159. The conduct described in paragraphs 150-158 constitutes a breach of the authorities referred to in Count 10.

Count 11

160. Section 2.2 of the M3P PD states that, prior to dispensing a drug such as an opioid, a pharmacist must enter all pertinent prescription and patient information into the patient's health record in the DPIN.

161. Patient [redacted] had been receiving high dose opioids from the Pharmacy since May 18, 2018. This patient is identified on his patient screen at the Pharmacy as having an address in Edmonton, Alberta and there is no PHIN associated with [redacted]s file.

162. Between May 18, 2018, and May 3, 2019, [redacted] had 28 prescriptions for oxycodone containing medications dispensed to [redacted] by the Pharmacy, including large quantities of oxycodone CR 80mg, oxycodone CR 40mg and Oxycocet®. As well, numerous prescriptions for gabapentin and naproxen were regularly dispensed. None of these prescriptions were sent to DPIN.

163. For prescriptions written for Oxycontin 40 and 80mg, both discontinued products in which there is no interchangeable equivalent, Mirza substituted generic oxycodone CR without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

164. These prescriptions were filled in intervals ranging from weekly supplies to three-week supplies.

165. The failure to enter the dispensing of large quantities of high dose opioid drugs into DPIN, as well as potentially dangerous drugs such as gabapentin, is a violation of the Code.

166. In addition, there is no documentation showing that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]s high dose of opioids.

Count 12

167. Patient [redacted]. began receiving opioid prescriptions at the Pharmacy in or around September 2018). At that time, [redacted]'s dose was equivalent to 460mg MEQ/day.

168. As recently as July 1, 2019, [redacted]. had received dosages equivalent to 420mg MEQ/day, a decrease of -40mg MEQ/day from the initial dosages.

169. There is no documentation showing that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]'s high dose of opioids.

Count 13

170. Patient [redacted]. began receiving opioid prescriptions at the Pharmacy in or around July 2017. At that time, [redacted] 's dose was equivalent to 1155mg MEQ/day.

171. On May 3, 2019, [redacted] was prescribed Oxycontin 80mg to be taken as directed. Oxycontin was

a discontinued product for which there was no interchangeable equivalent. Mirza substituted generic oxycodone CR without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

172. As recently as July 24, 2019, [redacted] had received dosages equivalent to 810mg MEQ/day, a decrease of -345mg MEQ/day from the initial dosages.

173. There is no documentation showing that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]'s high dose of opioids.

Count 14

174. Patient [redacted]. began receiving opioid prescriptions at the Pharmacy in or around November 2018). At that time, [redacted]s dose was equivalent to 780mg MEQ/day.

175. On April 2, 2019, [redacted] was prescribed Oxycontin 80mg, one to two tablets four times daily. Oxycontin was a discontinued product for which there was no interchangeable equivalent, Mirza substituted generic oxycodone CR without documented authorization from the prescriber. Mirza made efforts to provide generic oxycodone CR to this patient rather than dispense the Oxy Neo product, which is less susceptible to diversion.

176. As recently as July 13, 2019, [redacted]. had received dosages equivalent to 1080mg MEQ/day, an increase of +300mg MEQ/day over the initial treatments.

177. There is no documentation showing that Mirza had been collaborating with prescribers to work towards a taper of patient [redacted]'s high dose of opioids.

Count 15

178. Section 78 of the Act states that pharmacists may not, in dispensing a drug pursuant to a prescription, substitute one drug for another or one brand of drug for another, without the consent of the prescriber.

179. The Pharmacy commonly switched prescriptions from naproxen regular release to naproxen enteric coated tablets without prescriber approval. Naproxen regular tablets and naproxen enteric coated tablets are not the same form of naproxen and are not listed as interchangeable on the *Manitoba Drug and Interchangeability Formulary*.

180. Patient [redacted] was prescribed naproxen regular release 500 mg but was dispensed naproxen 250mg EC tablets. No indication was made on the prescription hard copy or the computer file to indicate that the prescriber was consulted about this substitution.

Count 16

181. Section 78 of the Act states that pharmacists may not, in dispensing a drug pursuant to a prescription, substitute one drug for another or one brand of drug for another, without the consent of the prescriber.

182. The prescription for patient [redacted] called for naproxen 500mg tablets. Instead, Mirza chose to use naproxen enteric coated 250mg tablets. Pharmacy records showed that the patient directions

were correctly modified to account for the change in tablet strength. However, naproxen regular tablets and naproxen enteric coated tablets are not the same form of naproxen and are not listed as interchangeable on the *Manitoba Drug and Interchangeability Formulary*.

183. There is no documentation of consultation with the prescriber with respect to the substitution of naproxen.

Count 17, 18 and 19

184. Pursuant to subsection 2(2)(a) of the Act, a pharmacist may only engage in the prescribing of drugs that are designated within the regulations if they are qualified to do so. Subsection 2(3) of the Act requires that drugs only be dispensed pursuant to a prescription.

185. Subsection 18 of the Regulation requires that pharmacists only engage in those aspects of the practice of pharmacy in which they have the requisite knowledge, skill and judgment. Subsection 56(1)4 of the Regulation requires members who prescribe drugs to provide a written prescription to the patient and to advise them that they may choose to have the prescription dispensed at another pharmacy. Pharmacists may only prescribe if they have complied with applicable practice directions and have complied with the CDSA.

186. The Prescribing PD requires that pharmacists not prescribe a drug unless they have the knowledge, skill and judgment with regard to the drug and the condition for which it is prescribed and must document the directions for use and any follow-up plan.

187. The ECP PD requires that pharmacists not sell an exempted codeine preparation unless it is pursuant to a prescription that is reduced to writing and meets all legal requirements.

188. On December 6, 2018, Mirza had prescribed, using her own name as prescriber, 5 drugs to patient [redacted]: naproxen EC 250mg, acetaminophen 500mg, citalopram 20mg, clonazepam 0.5mg and Lenoltec #1 with codeine (*Schedule 43*). There were no prescriptions on record for these drugs or received as transfers from other pharmacies on [redacted]'s file around this time.

189. The naproxen EC 250mg, acetaminophen 500mg, and citalopram 20mg were dispensed to [redacted]. and the clonazepam 0.5mg and Lenoltec #1 with codeine were entered as deferred prescriptions. These deferred prescriptions were active and available for fill by another staff person. None of these medications were previously dispensed to [redacted] by the Pharmacy, and there was no history between the patient and the Pharmacy prior to the prescribing of these medications by Mirza. [redacted]. subsequently became a patient of [redacted] and received prescriptions for escitalopram, Tylenol #3 and lorazepam.

190. Mirza was not qualified to prescribe any of these medications to patient [redacted]. in December of 2018. In addition, Mirza prescribed and dispensed the citalopram to [redacted] despite the DPIN history showing that the patient had received a 30-day supply of this medication only two days before. Mirza also prescribed and dispensed naproxen to [redacted] even though another such prescription had been filled at another pharmacy on the same day. The clonazepam prescription was prescribed and deferred even though the patient had been dispensed a 14-day supply only two days previously.

191. The prescription for Lenoltec #1 was made without an Exempted Codeine Preparation Patient Assessment being completed.

Count 20, 21 and 22

192. On December 6, 2018, Mirza had prescribed, using her own name as prescriber, four drugs to patient [redacted]: citalopram 10mg, clonazepam 0.5mg, Lenoltec #1 with codeine and acetaminophen 500mg. There are no prescriptions on record for these drugs or received as copies from any other pharmacy present on the file.

193. The acetaminophen 500mg and citalopram 10mg were dispensed to [redacted] and the clonazepam 0.5mg and Lenoltec #1 with codeine were entered as deferred prescriptions. These deferred prescriptions were active and available for fill by another staff person. None of these medications were previously dispensed to [redacted]. by the Pharmacy, and there was no history between the patient and the Pharmacy prior to the prescribing of these medications by Mirza. [redacted] subsequently became a patient of [redacted] and received prescriptions for escitalopram, Tylenol #3 and clonazepam.

194. Mirza was not qualified to prescribe any of these medications to patient [redacted] . in December 2018. In addition, Mirza prescribed and dispensed the citalopram to [redacted] despite the DPIN history showing that the patient had received a 30-day supply of this medication almost two months previously. The patient was not eligible for continued care because they were new to the Pharmacy and there was no prescription on record at the pharmacy. [redacted]. had also received a seven-day supply of clonazepam just two days before Mirza created a clonazepam prescription in his file.

195. The prescription for Lenoltec #1 was made without an Exempted Codeine Preparation Patient Assessment being completed.

Count 23

196. The Investigator determined, by reviewing prescription files at the Pharmacy, that on or about July 27, 2017, Mirza had prescribed, using her own name as prescriber, four drugs to patient [redacted]: warfarin 1mg, metoprolol 25mg, zopiclone 7.5mg and hydrochlorothiazide 25mg. There are no prescriptions on record for these drugs or received as copies from any other pharmacy present on the file. All these medications were dispensed to [redacted]. on or about July 27, 2017.

197. None of these medications were previously dispensed to [redacted] by the Pharmacy, and there was no history between the patient and the Pharmacy prior to the prescribing of these medications by Mirza.

198. Mirza was not qualified to prescribe any of these medications to patient [redacted] . in July 2017.

Count 24

199. The Investigator determined, by reviewing prescription files at the Pharmacy, that on or about February 11, 2017, Mirza had prescribed, using her own name as prescriber, rizatriptan ODT 10mg to patient [redacted] The prescription was made based on a transfer report from Sobeys Pharmacy #5155 that had no refills. This medication was dispensed to [redacted] . on or about February 7, 2017.

200. This medication had not been previously dispensed to [redacted]. by the Pharmacy, and he only prescription filled by the Pharmacy to [redacted] prior to this interaction was for one prescription of gabapentin.

201. Mirza was not qualified to prescribe this medication to patient [redacted]. in February 2017. The patient was not eligible for continued care because there was no previous prescription for rizatriptan on record at the pharmacy.

Count 25

202. The Investigator determined, by reviewing prescription files at the Pharmacy, that on or about October 10, 2018, Mirza had prescribed, using her own name as prescriber, two drugs to patient [redacted]": furosemide 40mg and montelukast 10mg. The prescription was made based on a transfer report from Pharma Plus Drugmart #4815 that had no refills. These medications were dispensed to [redacted]. on or about October 10, 2018.

203. None of these medications were previously dispensed to [redacted] by the Pharmacy, and there was no history between the patient and the Pharmacy prior to the prescription of these medications.

204. Mirza was not qualified to prescribe any of these medications to patient [redacted]. in October 2018. The patient was not eligible for continued care because they were new to the pharmacy and there was no previous prescription for these drugs on record at the pharmacy.

Count 28

205. The Incidents PD requires that pharmacy managers ensure that the pharmacy has written policies and procedures in place for addressing, reporting, investigating, documenting, disclosing, and learning from medication incidents. The Incidents PD also outlines the steps to be taken in the event of discovery of a medication incident in a community pharmacy setting.

206. The Pharmacy was inspected on December 11, 2017, by the College and was found to have been operating without a means of documenting dispensing errors, incidents, or near-miss events. The College inspector advised Mirza that she needed to maintain an error/discrepancy logbook and review it regularly as part of an ongoing continuous improvement policy. Mirza indicated in her response of January 16, 2018, that she was compliant with this request.

207. During the investigation, Mirza was requested to produce a copy of the error/discrepancy file. She advised the Investigator that she did not have one.

Count 29

208. Pharmacists require a pharmacist license to engage in the practice of pharmacy.

209. Section 2 of the Act sets out the actions which the practice of pharmacy consists of, including:
    a. The compounding, dispensing and retail sale of drugs;
    b. Monitoring drug therapy and advising on the contents, therapeutic values and hazards of drugs;
    c. Advising on the use, calibration, effectiveness and hazards of devices used in connection with drugs or to monitor health status;
    d. Identifying and assessing drug-related problems and making recommendations to prevent or resolve them.

210. On June 24, 2019, Mirza signed an agreement with the College whereby she voluntarily surrendered her pharmacist license. In doing so, Mirza agreed at that time not to practice pharmacy, nor work in a pharmacy in Manitoba, until her pharmacist license was reinstated by

the College.

211. On December 19, 2019, Mirza was found to be practising as a pharmacist in the dispensary at the Pharmacy. Mirza had a patient's bubble pack schedule on the counter in front of her and was working on a drug tapering schedule for a patient. At that time, her pharmacist license had not yet been reinstated, nor the Voluntary Surrender agreement revoked.

212. The monitoring of a drug therapy for a patient constitutes the practice of pharmacy, which is a task that only a licensed pharmacist may perform.

The Amended August 2020 Notice

213. During the investigation related to the January 2020 Notice, Ms. Mirza had engaged in pharmacist prescribing that was not compliant with legislation. A follow-up investigation was undertaken to determine the extent of this prescribing.

214. On January 3, 2020, then-Assistant Registrar, Quality Assurance, Ms. Chatterjee-Mehta wrote to the Assistant Deputy Minister of Health requesting the prescribing data for Mirza from the Drug Program Identification Network ("DPIN") for the period of January 1, 2018 to June 24, 2019.

215. On January 17, 2020, the Assistant Deputy Minister of Health provided a record of the DPIN entries for prescriptions dispensed by Mirza between January 1, 2018 and June 24, 2019.

216. A review and analysis of all prescriptions entered into the Manitoba DPIN between January 1, 2018 and June 24, 2019 which were written by Mirza found two categories of alleged violations: (1) the prescribing of NAPRA National Drug Schedule ("NDS") Schedule 1 drugs or vaccines while not an authorized prescriber; and (2) the inappropriate prescribing of continued care prescriptions.

217. The Investigator submitted an Investigation Report on February 20, 2020 (the "Second Report").

218. On March 31, 2020, then-chair of the Committee, Pat Trozzo, wrote to Mirza to advise that serious concerns related to her prescribing practices had been uncovered by the investigation.

219. On May 8, 2020, the Investigator submitted a subsequent report on Mirza's provision of injectable drugs.

220. On May 19, 2020, Ms. Chatterjee-Mehta wrote to the Director of Communicable Disease Control for the purpose of obtaining information regarding five specific patients from the Public Health Information Management System ("PHIMS").

221. On June 15, 2020, the Director of Communicable Disease Control provided immunization records of the five patients requested.

222. On June 18, 2020, the Investigator submitted a follow-up report with respect to Mirza's administration of injectable medications (Schedule 54).

223. The August 2020 Notice was issued on August 17, 2020.

Counts 1(a) to (d)

224. In order to prescribe Twinrix®, Mirza would have to have been an extended practice pharmacist in accordance with section 118(3) of the Regulation.

225. Mirza was not an extended practice pharmacist on January 6, 2018.

226. Mirza prescribed one dose of Twinrix® to [redacted] on January 6, 2018. [redacted]. was provided with the Twinrix® at the Pharmacy, and subsequently attended at the adjacent clinic for administration of the vaccine. The nurse practitioner and [redacted] family physician administered the balance of the Twinrix® regimen to [redacted]

227. There was no documented consent obtained from patient [redacted] for the prescribing and dispensing of Twinrix®.

Counts 2(a) to (d)

228. Mirza prescribed and dispensed Zostavax® vaccine to patient [redacted]. on May 15, 2018. The prescription was entered into DPIN and into the Pharmacy computer system as being prescribed and dispensed by Mirza. There was no documentation about who administered this vaccine at the Pharmacy.

229. Zostavax® is an NDS Schedule 1 vaccine and requires a prescription from an authorized prescriber.

230. Mirza was neither an authorized nor qualified prescriber for this vaccine on May 15, 2018.

231. Mirza did not file an original prescription of this prescription in the files of the Pharmacy.

232. There was no consent form obtained from patient [redacted]. for the prescribing and dispensing of Zostavax®.

Counts 3(a) to (d)

233. Mirza prescribed and dispensed Havrix® to patient [redacted] on December 12, 2018.

234. Mirza was not an authorized nor qualified prescriber for this vaccine on December 12, 2018, as Havrix® is an NDS Schedule 1 vaccine and requires a prescription from an authorized prescriber.

235. The Pharmacy had no previous dispensing relationship with this patient prior to December 12, 2018.

236. Havrix® is usually prescribed as a two-dose regimen, with a booster dose following the original dose by six to 12 months to ensure long-term immunity.

237. There are no records in the Pharmacy files as to whether this prescription was for an original dose or a booster. There is also no notation indicating whether the patient needs to have a second booster dose administered.

238. There was no consent form obtained from patient [redacted] for the prescribing and dispensing of Havrix®.

Counts 4(a) to (d)

239. Mirza prescribed and dispensed two NDS Schedule 1 vaccines to [redacted]: Typhim Vi® .5ml and Vaqta Ped® 0.5ml.

240. There was no previous dispensing history between the Pharmacy and [redacted].

241. Mirza was neither an authorized nor qualified prescriber for these vaccines on February 21, 2019.

242. There is no evidence that any authorized prescriber was involved in prescribing or administering these therapies.

243. There was no documentation about who administered this vaccine.

244. Mirza generated a Refill Authorization Form which she addressed to herself, and used this document as the prescription. Mirza prescribed the pediatric version of Vaqta®, despite the patient being 35 years old at the time of the prescription.

245. There is no record on the Pharmacy patient history of the patient receiving the recommended second dose of Vaqta®.

246. There was no consent form obtained from patient [redacted] for the prescribing and dispensing of either of the Typhim Vi® .5ml or the Vaqta Ped® .5ml.

Counts 5(a) to (d)

247. Mirza prescribed and dispensed two NDS Schedule 1 vaccines to [redacted]: Typhim Vi® .5ml and Vaqta Ped® 0.5ml.

248. There was no previous dispensing history between the Pharmacy and [redacted].

249. Mirza was neither an authorized nor qualified prescriber for these vaccines on February 21, 2019.

250. There is no evidence that any authorized prescriber was involved in prescribing or administering these therapies.

251. There was no documentation about who administered these vaccines.

252. Mirza generated a Refill Authorization Form which she addressed to herself and used this document as the prescription hard copy. Mirza prescribed the pediatric version of Vaqta®, despite the patient being 34 years old at the time of the prescription.

253. There is no record on the Pharmacy patient history of the patient receiving the recommended second dose of Vaqta®.

254. There was no consent form obtained from patient [redacted] for the prescribing and dispensing of either of the Typhim Vi® .5ml or the Vaqta Ped® .5ml.

Counts 6(a) to (c)

255. Mirza prescribed and dispensed a total of 40 doses of Fragmin® (Dalteparin) to patient [redacted]

in 4 prescriptions between January 2018 and December 2018). Fragmin® is an anticoagulant requiring daily subcutaneous injections. It is a high-risk drug and has a significant risk of causing patient harm when used in error.

256. Mirza prescribed and dispensed five daily doses on October 12, 2018, 15 daily doses on December 11, 2018, and 10 daily doses on December 27, 2018. Each of the prescriptions that Mirza generated indicated that she was prescribing the Fragmin® as continued care prescriptions but did not meet the minimum documentation requirements for informing the regular prescriber.

257. Of the three prescription hard copies that Mirza placed in the Pharmacy files, only one had any indication that the refills were requested from a prescriber. Also, due to the high-risk nature of this drug, quantities prescribed to the patient on a continued care basis should have been minimized.

Counts 7(a) to (b)

258. Mirza prescribed and dispensed a seven-day course of prednisone 50mg tablets to patient [redacted] as a continued care prescription in January 2018. Patient [redacted] was 14 years old at the time of Mirza's prescription, bringing into question the accuracy of Mirza's assessment of an exacerbation of COPD.

259. The patient had previously received a similar seven-day course three months earlier from a pediatrician, and another seven-day course seven months prior to that. The patient was neither a regular nor continuous user of prednisone.

260. On the prescription that Mirza filed, she stated that she prescribed prednisone because the patient was having an "exacerbation of COPD." There were no documented attempts to obtain a refill from the original prescribing physician and nothing to indicate that the prescriber had been notified of the continued care fill.

Counts 8(a) to (c)

261. Mirza prescribed four tablets of Cialis® (tadalafil), an erectile dysfunction drug, for patient [redacted] as a continued care prescription in February 2018. The patient history shows roughly monthly prescribing for this drug, and the patient was a regular patient of the Pharmacy.

262. The generated refill fax request that was used as the prescription by Mirza for the filling of the Cialis® had her listed as the prescribing physician and not the patient's regular prescribing physician.

263. There was no documentation that any attempt was made to request a refill from the patient's physician before issuing the continued care prescription. There is no evidence that Mirza notified the physician that she had prescribed a continued care prescription.

Counts 9(a) to (c)

264. Mirza prescribed an injection of Depo-Provera 150mg to patient [redacted] on a continued care basis in May 2018. Mirza prescribed and dispensed the injection, then sent a fax to the original prescribing physician notifying [redacted] of [redacted] continued care prescription. The physician replied stating that [redacted] needed to see the patient, but this note came too late as Mirza had already

prescribed and dispensed the drug.

265. Mirza recorded on the prescription hard copy that a pregnancy test was negative.

266. There was no documentation on the patient file to show that Mirza had attempted to contact the physician for refills. Mirza also did not document why she prescribed the injection at that time, as the days elapsed since the previous injection was still two weeks short of the three-month effective duration of the previous dose, permitting a reasonable period of time to obtain a prescription refill from the physician.

Counts 10(a) and (b)

267. Mirza prescribed four tablets of Cialis® (tadalafil) for patient [redacted]. as a continued care prescription in April 2019. The Pha1macy had only dispensed a single prescription for patient [redacted]18 months earlier, indicating there was no urgent need for the medication or that ongoing therapy was established.

268. There was no documentation that any attempt was made to request a refill from the patient's physician before issuing the continued care prescription. There is no evidence that Mirza notified the physician that she had prescribed a continued care prescription.

The March 2021 Notice

269. On April 6, 2020, Mirza. emailed a letter to the Committee, in advance of her April 7, 2020, videoconference before the Committee, to request that they consider reinstatement of her practising pharmacist license.

270. On April 7 and 9, 2020, Mirza met with the Committee and discussed the requirements that must be satisfied prior to the re-issuance of her pharmacist practicing license.

271. On April 9, 2020, counsel for Mirza sent an email to the Committee and counsel for the Committee, which discussed possible re-licensure conditions.

272. On May 1, 2020, the Committee sent Mirza a letter which discussed potential conditions for re-licensure and advised her that a written undrtaking would be developed when all required information had been gathered.

273. On May 21, 2020, then-Registrar Ms. Lessard-Friesen sent a cease-and-desist letter to Mirza to advise her that the te1ms of the Voluntary Surrender remained in effect, and to direct her to immediately cease the practice of pharmacy, including working in any pharmacy.

274. On June 12, 2020, then-Registrar Ms. Lessard-Friesen referred the matters involving Mirza and her unauthorized presence at the Pharmacy on May 20, 2020, to the Committee.

275. On June 19, 2020, Mirza provided a response to the June 12, 2020, Registrar's Referral.

276. The Investigator submitted an Investigation Report on February 12, 2021 (the "Third Report").

277. The March 2021 Notice was issued on March 10, 2021.

Count 1

278. Pharmacists require a pharmacist license to engage in the practice of pharmacy.

279. Section 2 of the Act sets out the actions which the practice of pharmacy consists of, including:
    a. The compounding, dispensing and retail sale of drugs;
    b. Monitoring drug therapy and advising on the contents, therapeutic values and hazards of drugs;
    c. Advising on the use, calibration, effectiveness and hazards of devices used in connection with drugs or to monitor health status;
    d. Identifying and assessing drug-related problems and making recommendations to prevent or resolve them.

280. On June 24, 2019, Mirza signed an agreement with the College whereby she voluntarily surrendered her pharmacist license. In doing so, Mirza agreed at that time not to practice pharmacy, nor work in a pharmacy in Manitoba, until her pharmacist license was reinstated by the College.

281. On May 20, 2020, Mirza was found to be working in the dispensary at the Pharmacy. At that time, her pharmacist license had not yet been reinstated, nor the Voluntary Surrender agreement revoked.

282. Mirza admitted in her response to the June 12, 2020, Registrar's Referral that she was present and working in the dispensary on May 11, 14, 19 and 20.

283. The Investigator reviewed prescription hard copies from April and May of 2020 to determine whether Mirza was present within the Pharmacy. By examining notations made by Mirza on prescription hard copies, the Investigator verified that Mirza was present in the dispensary on May 11, 19 and 20.

284. The Investigator also determined that Mirza was present in the Pharmacy and working in the dispensary on April 15, April 21, May 4 and May 5.

285. On those dates, Mirza filled prescriptions, accessed patient records through the pharmacy software, conversed with patients, documented care notes and made fax requests to prescribers.

286. The prescription hard copies reviewed by the Investigator also indicated that on numerous occasions, Mirza received verbal prescription information from a physician, or was involved in the clinical care of a patient, which are tasks that only a licensed pharmacist may perform.

Decision

After reviewing the authorities, documentary evidence, the agreed facts and hearing the submissions of counsel for the Complaints Committee and the submissions of Mirza, the Panel has:

1. accepted the Complaint Committee's request to enter a stay of counts 27 and 30 as set out in the Amended January 2020 Notice;

2. accepted Mirza's plea of guilty to counts 1-26, 28 and 29 as set out in the Amended January 2020 Notice.

3. accepted the Complaint Committee's request to enter a stay of count 11 as set out in the Amended August 2020 Notice.

4. accepted Mirza's plea of guilty to counts 1-10 as set out in the Amended August 2020 Notice.

5. accepted the Complaint Committee's request to enter a stay of count 2 as set out in the March 2021 Notice.

6. accepted Mirza's plea of guilty to count 1 as set out in the March 2021 Notice.

7. found that pursuant to section 54 of the Act, Mirza is guilty of professional misconduct and displayed a lack of skill or judgment in the practice of pharmacy.

8. accepted the recommended disposition of legal counsel for the Complaints Committee and ordered that:
    a. this decision of the Panel be published and made available to the public;
    b. Mirza pay a fine of $20,000.00;
    c. Mirza be suspended from practice for one year, with credit for 10 months of the time during which she had voluntarily surrendered her pharmacist's licence;
    d. a restriction be placed on Mirza's practicing license for five years, to be effective from the date of her return to practice, that she cannot be a pharmacy manager or preceptor for five years; and
    e. Mirza pay a contribution to the costs of the investigation and hearing in the amount of $130,000.00, which sum is to be paid in full within five years of the date of the Discipline Committee's decision

In arriving at its decision, the Panel considered:

- Mirza's admission of guilt, which although it lessened what would have been a very lengthy hearing, did not alleviate the extensive time and expense associated with hearing preparation;
- that a portion of the costs associated with the discipline process should be recovered from the member who is guilty of the professional misconduct;
- the costs ordered in this decision are less than 40% of the total costs of the hearing;
- the number and gravity of the admitted allegations which included but was not limited to narcotic and opioid dispensing and reporting charges which could have led to potential opioid diversion and patient safety concerns due to Mirza's lack of skill or judgment;
- that Mirza prescribed and dispensed NAPRA Schedule 1 medications without proper authorization on multiple occasions and displayed a lack of knowledge or regard for the Regulations governing the profession;
- Mirza's individual circumstances and character as presented by her in her submission; and
- the duty of the committee to uphold the highest standards of practice to protect the public. In that regard, the charges against Mirza displayed professional misconduct in the practice of pharmacy and her role as a pharmacy manager.

In conclusion, 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 will be protected and the public's confidence maintained.

DATED at Winnipeg, Manitoba this 6th day of March, 2024.

Per:
Glenda Marsh
Chair, Discipline Panel

Note: The original Notice of Hearing was amended. Edits are intentional to denote changes from the original.

NOTICE OF HEARING

TAKE NOTICE THAT a hearing will be conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on Monday, February 10, 2020, at 9:0 0 a.m., or as soon thereafter as the matter may be heard, with respect to charges formulated by the College alleging that you, being a pharmacist under the provisions of T*he Pharmaceutical Act*, C.C.S.M. c.P60 (the "Act') and a registrant of the College, are guilty of professional misconduct, conduct unbecoming a member, or have displayed a lack of knowledge or 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 Rossmere Pharmacy (the "Pharmacy"), Unit D - 1046 Henderson Highway, Winnipeg, Manitoba;

1. On or about June 15, 2019, you:
    a. delivered vials containing clindamycin 300mg and naproxen enteric-coated 250mg, to a Dairy Queen restaurant [redacted] (the "DQ"), in contravention of: subsections 2.3 .1 and 2.6 of the *Practice Direction: Drug Distribution and Storage* (the "DDS Practice Direction"); subsection 2.1 of the *Practice Direction Delegation of Dispensing to Other Health Professionals*; and, Statements I, IV and VII of the *Code of Ethics* (the "Code"), or any of them;
    b. delivered a vial containing acetaminophen with codeine 30mg, to the DQ, in contravention of: section 43 of the Narcotic Control Regulations, C.R.C., c. 1041, (the "NCRs"); and, Statements I, IV and VII of the Code, or any of them;
    c. failed to affix labels with the required information to the vials referred to in paragraph (a) above, in contravention of subsection C.01.005(1) of the Food and Drug Regulations, C.R.C., c. 870 (the "FDRs");
    d. sold the medication referred to in paragraph (b) above, without affixing the warning sticker and patient information handout in contravention of, respectively, subsections C.01.005.l(a) and (b) of the FD Rs;
    e. failed to affix the required drug labels on the medication referred to in paragraphs (a) and (b) above, in contravention of subsection 71 (1) of The Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation");
    f. failed to make a prescription record at the Pharmacy of the medication referred to in paragraphs (a) and (b) above, in contravention of subsection 70(1) of the Regulation;
    g. failed to make a record at the Pharmacy of the prescription order for the medication referred to in paragraph (b) above, in contravention of section 3 8 of the NCRs; and
    h. failed to maintain a narcotic prescription record at the Pharmacy of the prescription order for the medication referred to in paragraph (b) above, in contravention of section 40 of the NCRs;

2. In your capacity as pharmacy manager and/or pharmacist, you:
    a. failed to meet the responsibilities of a pharmacy manager by delegating responsibility related to narcotic inventory management to a pharmacy assistant in contravention of the Narcotic and Controlled Drug Accountability Guidelines (the "Accountability Guidelines") and section 65 of the Regulation, or either of them;
    b. failed to secure pharmacy records from unauthorized access, theft, use or loss in contravention of: subsections 56(1) 12 and 56(1) 15 of the Regulation; sections 2.2.3 and 2.2.8 of the Pharmacy Facilities Practice Direction (the "Facilities PD"); and, section 2.4.1 of the Records and Information Practice Direction (the "Records PD"), or any of them;
    c. failed to manage and/or protect the controlled substances inventory at the Pharmacy,

in contravention of: subsection 56(1)(13) of the Regulation; section 43 of the NCRs; section G.03.012 of the FD Rs; subsection 7(1)(b) of the Benzodiazepine and Other Targeted Substances Regulations, SOR/2000-217,(the "BOTSRs"); and, sections 2.3, 3.0, and 4.0 of the DDS Practice Direction, or any of them;

d. failed to investigate discrepancies between dispensed quantities and controlled substances sales reports, in contravention of section 43 of the NCRs, and section 2.3.2.3 of the DDS Practice Direction, or either of them;
e. between May 2016 and July 24, 2018, and between October 26, 2018 and March 9, 2019, failed to conduct quarterly inventory counts of controlled substances in contravention of: section 43 of the NCRs; subsection 7(1)(b) of the BOTSRs; section G.03.012 of the FD Rs; and section 2.3.2.2 of the DDS Practice Direction, or any of them.
f. between May 2016 and December 2017, and between February 2018 and June 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 FD Rs; subsection 7(1)(b) of the BOTS Rs; and, section 2.3.2.5 of the DDS Practice Direction, or any of them
g. between May 2016 and December 2017, and between February 2018 and June 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;
h. failed to perform and record a physical count of the expired and/or patient returned controlled substances in contravention of section 2.3.2.2 of the DDS Practice Direction and the Accountability Guidelines, or either of them;
i. failed to retain acquisition records for controlled substances in contravention of subsection 79(2)(e) of the Regulation;
j. failed to retain prescription records for controlled substances in contravention of subsection 79(2)(a) of the Regulation;
k. improperly disposed of drugs listed in a schedule to the Controlled Drugs and Substances Act, SC 1996, c 19 (the "CDSA") in contravention of: sections 2.4.1.3 and 2.4.1.4 of the DDS Practice Direction; subsection 2(2)(b) of the BOTSRs; and, Statement I of the Code, or any of them; and
l. failed to secure the Pharmacy from unauthorized access to the narcotic safe, and prepared prescriptions, or either of them, in contravention of sections 2.2.3, 2.2.8, 2.2.14.1 and 2.2.1 4.4 of the Facilities PD, or any of them;

3. Between December 19, 2017 and January 11 1, 2018, you dispensed opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections 18(a), 69(4), 78(1)(b), 83(a), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the *Practice Direction: Ensuring Patient Safety* (the "EPS Practice Direction"); Recommendations 9, and 10 of The 2017 *Canadian Guideline for Opioids for Chronic Non-Cancer Pain* (the "Guideline"); and, Statements I, II, VII, and IX of the Code, or any of them;

4. Between December 28, 2018 and February 14, 2019, you dispensed opioids for patient [redacted] either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections, 18(a), 69(4), 78(1)(b), 83(a), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9, and 10 of the Guideline; and Statements I, II, VII, and IX of the Code, or any of them;

5. Between February 25, 2019 and March 15, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, therapeutic duplication, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and Statements I, II, VII, and IX of the Code, or any of them;

6. Between ~~January 22, 2019~~ August 7, 2018 and June 13, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted]" with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, therapeutic duplication, and inappropriate dmg substitution, in contravention of: section 78 of the Act; subsections, 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and Statements I, II, VII, and IX of the Code, or any of them;

7. Between ~~February 2 2019~~ January 12, 2019 to June 20, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections 18(a), 69(4), 78(1)(b), 83(a), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline, and Statements I, II, VII, and IX of the Code, or any of them;

8. Between April 30, 2019 to June 20, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, therapeutic duplication, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections, 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and Statements I, II, VII, and IX of the Code, or any of them;

9. Between August 13, 2018 and June 12, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, therapeutic duplication, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections, 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and Statements I, II, VII, and IX of the Code, or any of them;

10. Between August 7, 2018 and June 20, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, and therapeutic duplication, in contravention of: subsections 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and Statements I, II, VII, and IX of the Code, or any of them;

11. Between May 18, 2018 to April 25, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration,

inappropriate drug substitution, and failed to use the patient's Personal Health Information number (PHIN) and/or a "pseudo PHIN" in contravention of: section 78 of the Act; subsections 18(a), 69(4), 78(1)(b), 83(a), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; Statements I, II, VII, and IX of the Code; and, section 2.2 of the Practice Direction: M3P Information Entered into DPIN, or any of them;

12. Between September 6, 2018 and June 20, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, and therapeutic duplication, in contravention of: subsections 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and, Statements I, II, VII, and IX of the Code, or any of them;

13. Between December 19, 2017 and June 17, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, therapeutic duplication, inappropriate drug substitution, in contravention of: section 78 of the Act; subsections 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and, Statements I, II, VII, and IX of the Code, or any of them;

14. Between November 14, 2018 and June 20, 2019, you dispensed or authorized the dispensing of opioids for patient [redacted] with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages of the opioids ordered, the frequency of administration, therapeutic duplication, and inappropriate drug substitution, in contravention of: section 78 of the Act; subsections 18(a), 69(4), 78(1)(b), 83(a), (d), (e), and (i) of the Regulation; sections 2.2, 2.3, and 2.4 of the EPS Practice Direction; Recommendations 9 and 10 of the Guideline; and, Statements I, II, VII, and IX of the Code, or any of them;

15. On or about May 17, 2018, with no or insufficient collaboration with the prescriber, you dispensed naproxen EC 250mg as an inappropriate drug substitution to patient [redacted] in contravention of section 78 of the Act;

16. On or about June 15, 2019, with no or insufficient collaboration with the prescriber, dispensed naproxen EC 250mg as an inappropriate drug substitution to patient [redacted] in contravention of section 78 of the Act;

17. On or about December 6, 2018, you prescribed citalopram 20mg, clonazepam .5mg, and naproxen EC 250mg to patient [redacted] in contravention of: subsection 2(2)(a) of the Act; subsection 2(1) of the CDSA; sections 18, ~~55~~56(1)(4), 119(c), and 120 of the Regulation; and, sections 2.3, 2.9.5, and 2.9.11 of the Prescribing Practice Direction, or any of them;

18. On or about December 6, 2018, you prescribed acetaminophen with codeine 8mg to patient [redacted] in contravention of subsection ~~55~~56(1)(4) of the Regulation and sections 2.1 and 2.9 of the Practice Direction Exempted Codeine Preparations, or any of them;

19. On or about December 6, 2018, you dispensed citalopram 20mg, and naproxen EC 250mg, to patient [redacted] without a valid prescription in contravention of subsection 2(3) of the Act, and subsection 69(1) of the Regulation, or either of them;

20. On or about December 6, 2018, you prescribed citalopram 10mg and clonazepam .5mg to patient [redacted] in contravention of: subsection 2(2)(a) of the Act; subsection 2(1) of the CDSA; sections 18, ~~55~~56(1)(4), 119(c), and 120 of the Regulation; and, sections 2.3, 2.9.5, and 2.9.11 of the Prescribing Practice Direction, or any of them;

21. On or about December 6, 2018, you prescribed acetaminophen with codeine 8mg to patient [redacted] in contravention of subsection ~~55~~56(1)(4) of the Regulation and sections 2.1 and 2.9 of the Practice Direction Exempted Codeine Preparations, or any of them;

22. On or about December 6, 2018, you dispensed citalopram 10mg to patient [redacted] without a valid prescription in contravention of subsection 2(3) of the Act, and subsection 69(1) of the Regulation, or either of them;

23. On or about July 27, 2017, you prescribed and dispensed warfarin 1mg, metoprolol 25mg, zopiclone 7.5mg, and hydrochlorothiazide 25mg, to patient [redacted] in contravention of: subsections 2(2)(a) and 2(3) of the Act; sections 18, ~~55~~56(1)(4), 69(1), and 119(c) of the Regulation; and, sections 2.3, 2.9.5, and 2.9.11 of the Prescribing Practice Direction, or any of them;

24. On or about February 11, 2017, you prescribed and dispensed rizatriptan ODT 10mg, to patient [redacted] in contravention of: subsections 2(2)(a) and 2(3) of the Act; sections 18, ~~55~~56(1)(4), 69(1), and 119(c) of the Regulation; and, sections 2.3, 2.9.5, and 2.9.11 of the Prescribing Practice Direction, or any of them;

25. On or about October 10, 2018, you prescribed and dispensed furosemide 40mg and montelukast 10 mg, to patient [redacted] in contravention of: subsections 2(2)(a) and 2(3) of the Act; sections 18, ~~55~~56(1)(4), 69(1), and 119(c) of the Regulation; and, sections 2.3, 2.9.5, and 2.9.11 of the *Prescribing Practice Direction*, or any of them;

26. You misrepresented facts to the College investigator in contravention of Statement VIII of the Code, in respect of the events referred to in Count# 1, by stating that you:
    a. attached a label and your business card to the bag containing the medication referred to in paragraph 1 (a) and (b) above;
    b. had written documentation from the patient, predating these events, requesting that medications be delivered to the patient without labels;
    c. had provided unlabelled medication to the patient on several occasions based on the written request referred to in paragraph 26(b) above; and
    d. did not dispense a narcotic as described in paragraph l (b) above;

[redacted]

28. You failed to maintain a medication incident log in contravention of sections 3.1 and 3.2 of the Practice Direction Medication Incidents and Discrepancies or Near-Miss Events;

29. In or about December 2019, you engaged in the practice of pharmacy without a valid pharmacist licence in contravention of subsection 16(1) of the Act, Statement VIII of the Code, or either of

them; and,

[redacted]

AND FURTHER TAKE NOTICE THAT if the Discipline Committee finds you to be guilty of professional misconduct, conduct unbecoming a member, or having displayed a lack of knowledge or skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above as alleged or at all, you may be liable to sanction in accordance with section 55 of the Act, including reprimand, fine, suspension or cancellation of certificate of registration, pharmacist licence or pharmacy licence and your name may be struck off the Register of the College.

DATED at Winnipeg, Manitoba this 8th day of January, 2020.

Per:
Susan Lessard-Friesen
Registrar

Note: The original Notice of Hearing was amended. Edits are intentional to denote changes from the original.

Note: The original Notice of Hearing was amended. Edits are intentional to denote changes from the original.

NOTICE OF HEARING

TAKE NOTICE THAT a hearing will be conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on Tuesday, September 22, 2020, at 9:00 a.m., or as soon thereafter as the matter may be heard, with respect to charges formulated by the College alleging that you, being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c.P60 (the "Act") and a registrant of the College, are guilty of professional misconduct, conduct unbecoming a member, or have displayed a lack of knowledge or 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 Rossmere Pharmacy (the "Pharmacy"), Unit D - 1046 Henderson Highway, Winnipeg, Manitoba;

1. a) on our about January 6, 2018, you prescribed and dispensed Twinrix ®, a NAPRA Schedule 1 vaccine, to patient [redacted], without authorization to prescribe that drug, in contravention of: subsection 2(2)(a) of the Act; subsections 18, 56(1)6, and 118 of the Regulation; and subsection 2.3, of the Prescribing PD;

   b) in prescribing and dispensing the drug referred to above, you failed to create and maintain a complete prescription record in contravention of: subsections 121(1)(i) and 121(2) of the Regulation; sections 2.9.9, 2.9.10, 2.9.11 and 2.9.12 of the Prescribing PD, or any of them;

   c) in prescribing and dispensing the drug referred to above, you failed to obtain the required consent form from patient [redacted] or their agent, in contravention of subsections 2.1.5 and section 2.4 of the Prescribing and Dispensing PD, or either of them; and,

   d) you failed to create and maintain a record of the prescription and dispensing of the drug referred to above in contravention of subsections 56(1)12 and 79(2)(g) of the Regulation, or either of them;

2. a) on or about May 15, 2018, you prescribed, dispensed, and directed the injection of Zostavax® vaccine, a NAPRA Schedule 1 vaccine, to patient [redacted] without authorization to prescribe that drug, in contravention of: subsection 2(2)(a) of the Act; subsections 18, 56(1)6, and 118 of *The Pharmaceutical Regulation,* Man Reg 185/2013 (the "Regulation"); and, subsection 2.3 of the *Practice Direction: Prescribing* (the "Prescribing PD");

   b) in prescribing and dispensing the drug referred to above, you failed to create and maintain a complete prescription record in contravention of: subsections 121(1)(i) and 121(2) of the Regulation; and, sections 2.9.9, 2.9.10, 2.9.11 and 2.9.12 of the Prescribing PD, or any of them;

   c) in prescribing and dispensing the drug referred to above, you failed to obtain the required consent form from patient [redacted] or their agent, in contravention of subsections 2.1.5. and 2.4 of the Practice Direction: Prescribing and Dispensing (the "Prescribing and Dispensing PD"), or either of them; and,

   d) you failed to create and maintain a record of the prescription and dispensing and failed to maintain a record of the administration of the drug referred to above, in contravention of subsections 56(1)12, and 79(2)(g) of the Regulation, or either of them;

3. a) on ~~our~~ or about December 12, 2018, you prescribed and dispensed Havrix ® 1440, ~~and directed the injection~~ of a NAPRA Schedule 1 vaccine, to patient [redacted] without authorization to prescribe that drug, in contravention of: subsection 2(2)(a) of the Act; subsections 18, 56(1)6, and 118 of the Regulation; and section 2.3 of the Prescribing PD, or any of the;

   b) in prescribing and dispensing the drug referred to above, you failed to create and maintain a complete prescription record in contravention of: subsections 121(1)(i) and 121(2) of the Regulation; and sections 2.9.9, 2.9.10, 2.9.11. and 2.9.12 of the Prescribing PD, or any of the them;

   c) in prescribing and dispensing the drug referred to above, you failed to obtain the required consent form from patient [redacted], or their agent, in contravention of subsections 2.1.5 and 2.4 of the Prescribing and Dispensing PD, or either of them; and,

   d) you failed to create and maintain a record of the prescription and dispensing of the drug referred to above in contravention of subsections 56(1)12 and 79(2)(g) of the Regulation, or either of them;

4. a) on ~~our~~ or about February 21, 2019, you prescribed, dispensed, and directed the injection of Typhim Vi® .5 ml, and Vaqta Ped® .5ml, NAPRA Schedule 1 vaccines, to patient [redacted] without authorization to prescribe that drug, in contravention of: subsection 2(2)(a) of the Act; subsections 18, 56(1)6, and 118 of the Regulation; and, subsection 2.3, of the Prescribing PD, or any of them;

   b) in prescribing and dispensing the drug referred to above, you failed to create and maintain a complete prescription record in contravention of: subsections 121(1)(i) and 121(2) of the Regulation; sections 2.9.9, 2.9.10, 2.9.11, and 2.9.12 of the Prescribing PD, or any of them;

   c) in prescribing and dispensing the drug referred to above, you failed to obtain the required consent form from patient [redacted] or their agent, in contravention of subsections 2.1.5 and 2.4 of the Prescribing and Dispensing PD, or either of them; and,

   d) you failed to create and maintain a record of the prescription and dispensing and failed to maintain a record of the administration of the drug referred to above in contravention of subsections 56(1)12, and 79(2)(g) of the Regulation, or either of them;

5. a) on our about February 21, 2019, you prescribed, dispensed, and directed the injection of Typhim Vi® .5 ml, and Vaqta Ped® .5ml, NAPRA Schedule 1 vaccines, to patient [redacted] without authorization to prescribe that drug, in contravention of: subsection 2(2)(a) of the Act; subsections 18, 56(1)6, and 118 of the Regulation; subsection 2.3 of the Prescribing PD, or any of them;

   b) in prescribing and dispensing the drug referred to above, you failed to create and maintain a complete prescription record in contravention of: subsections 121(1)(i) and 121(2) of the Regulation; sections 2.9.9, 2.9.10, 2.9.11. and 2.9.12 of the Prescribing PD, or any of them;

   c) in prescribing and dispensing the drug referred to above, you failed to obtain the required consent form from patient [redacted] or their agent, in contravention of subsections 2.1.5. and 2.4 of the Prescribing and Dispensing PD, or either of them; and,

   d) you failed to create and maintain a record of the prescription and dispensing and failed to maintain a record of the administration of the drug referred to above in contravention of

subsections 56(1)12, and 79(2)(g) of the Regulation, or either them;

6. a) on ~~four three~~ occasions between approximately ~~January~~ October 2018 and December 2018, you prescribed as a continued care prescription, and dispensed Fragmin®, to patient [redacted] in contravention of subsections 18 and 56(1)6 of the Regulation, or either of them;

   b) in prescribing and dispensing the drug referred to above, you failed to satisfy the requirements in authorizing a refill in contravention of: subsections 56(1)4, 122(1)(b), (c) and (f), 122(2), and 122(3)(c) of the Regulation, or any of them; and,

   c) you failed to create and maintain a record of the continued care prescription of the drug referred to above in contravention of subsection 56(1)12 of the Regulation;

7. a) on or about January 2018, you prescribed as a continued care prescription, and dispensed prednisone 50 mg, to patient [redacted] in contravention of subsections 18 and 56(1)6 of the Regulation, or either of them;

   b) in prescribing and dispensing the drug referred to above, you failed to satisfy the requirements in authorizing a refill in contravention of subsections 56(1)4, 122(1)(a)(b)(c) and (f), 122(2) and 122(3)(c) of the Regulation, or any of them; ~~and~~,

   ~~c) you failed to create and maintain a record of the continued care prescription of the drug referred to above in contravention of subsection 56(1)12 of the Regulation,~~

8. a) on or about February 2018, you prescribed as a continued care prescription, and dispensed Cialis ®, to patient [redacted] in contravention of subsections 18 and 56(1)6 of the Regulation, or either of them;

   b) in prescribing and dispensing the drug referred to above, you failed to satisfy the requirements in authorizing a refill in contravention of subsections 56(1)4, 122(1)(a), (b), and (f), and 122(2) of the Regulation, or any of them; and,

   c) you failed to create and maintain a record of the continued care prescription of the drug referred to above in contravention of subsection 56(1)12 of the Regulation;

9. a) on or about May 2018, you prescribed as a continued care prescription, and dispensed Depo-Provera® 150 mg, to patient [redacted], in contravention of subsections 18 and 56(1)6 of the Regulation, or either of them;

   b) in prescribing and dispensing the drug referred to above, you failed to satisfy the requirements in authorizing a refill in contravention of subsections 56(1)4, 122(1)~~(a)~~, (b), (c),(e) and (f), and 122(2) of the Regulation, or any of them; and,

   c) you failed to create and maintain a record of the continued care prescription of the drug referred to above in contravention of subsection 56(1)12 of the Regulation;

10. a) on or about April 2019, you prescribed as a continued care prescription, and dispensed Cialis ®, to patient [redacted] in contravention of subsections 18 and 56(1)6 of the Regulation, or either of them;

    b) in prescribing and dispensing the drug referred to above, you failed to satisfy the requirements

in authorizing a refill in contravention of subsections 56(1)4, 122(1)(a), (b), (c) and (f), 122(2), and 122(3)(c) of the Regulation, or any of them; and,

c) ~~you failed to create and maintain a record of the continued care prescription of the drug referred to above in contravention of subsection 56(1)12 of the Regulation;~~

[redacted]

AND FURTHER TAKE NOTICE THAT if the Discipline Committee finds you to be guilty of professional misconduct, conduct unbecoming a member, or having displayed a lack of knowledge or skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above as alleged or at all, you may be liable to sanction in accordance with section 55 of the Act, including reprimand, fine, suspension or cancellation of certificate of registration, pharmacist licence or pharmacy licence and your name may be struck off the Register of the College.

DATED at Winnipeg, Manitoba this 17th day of August, 2020.

Per:
Susan Lessard-Friesen
Registrar

NOTICE OF HEARING

TAKE NOTICE THAT a hearing will be conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on Tuesday, June 8, 2021, at 9:00 a.m., or as soon thereafter as the matter may be heard, with respect to charges formulated by the College alleging that you, being a pharmacist under the provisions of *The Pharmaceutical Act,* C.C.S.M. c.P60 (the "Act") and a registrant of the College, are guilty of professional misconduct, conduct unbecoming of a member, or have displayed a lack of knowledge or 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 April to May 2020, at Rossmere Pharmacy (the "Pharmacy"), Unit D - 1046 Henderson Highway, Winnipeg, Manitoba;

1. you engaged in the practice of pharmacy without a valid pharmacist licence in contravention of subsection 16(1) of the Act, Statement VIII of the Code of Ethics (the "Code"), or either of them; and,

[redacted]

AND FURTHER TAKE NOTICE THAT if the Discipline Committee finds you to be guilty of professional misconduct, conduct unbecoming a member, or having displayed a lack of knowledge or skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above as alleged or at all, you may be liable to sanction in accordance with section 55 of the Act, including reprimand, fine, suspension or cancellation of certificate of registration, pharmacist licence or pharmacy licence and your name may be struck off the Register of the College.

DATED at Winnipeg, Manitoba this 10th day of March, 2021.

Per:
Susan Lessard-Friesen
Registrar

In Memorium

In loving memory...

Lyle Merrell 7/30/2025