California State Board of Pharmacy
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Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

To: **Board Members**

Subject: **Executive Officer Report**

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a. <u>Biannual Report of the California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE) and the North American Pharmacist Licensure Examination (NAPLEX)</u>

Typically, twice a year the Board publishes a report on the passing rates for the CPJE and NAPLEX exams. Data included aggregate information for examinations administered between April 1, 2025, and September 30, 2025, inclusive.

Data reveals that the pass rate for the CPJE is higher for graduates from California schools versus other domestic schools. The data also reveals great variability among the passing rates for the California schools of pharmacy, ranging from a passing of 33.3% for some programs with others achieving a passing rate of over 80%.

Attachment 1 includes a copy of the report.

b. <u>Medication Error Reporting</u>

<u>Relevant Law:</u> Business and Professions Code (BPC) section 4113.1 establishes requirements for a community pharmacy to report, either directly or through a designated third party, medication errors to an entity approved by the Board.

<u>Background:</u> Following the state contracting process, as part of the Board's September 12, 2024 meeting, the Board approved the Institute for Safe Medication Practices (ISMP) as the entity to receive and review medication error reports under BPC section 4113.1. The contract was signed and approved on January 30, 2025.

As reported in April 2025, staff have been working with ISMP on implementation activities. In April, the Board and ISMP released information about how to register with ISMP. More recently, the Board released a fact sheet that included information about the California Medication Error Reporting (CAMER) data elements and updated the dedicated webpage on the Board's website to include this information. In the fact sheet, the Board advised licensees that medication errors that occur on or after September 1, 2025, must be reported to the CAMER system consistent with legal requirements established.

<u>Recent Update</u>:
Consistent with the contract, recently the Board received the first semi-annual report from ISMP providing summary information of medication error reports submitted to CAMER through December 2025.

The report notes that between July and December 2025, a total of 9,653 medication error reports were submitted to the CAMER system. Medication error reports were received from the following:

- 6,352: community chain pharmacies
- 1,449: non-chain community pharmacies
- 897: mail order pharmacies
- 568: closed-door pharmacies
- 266: specialty pharmacies
- 121: hospital outpatient pharmacies

Information included in the report (Table 2) reveal that 93.6% of the medication errors report no harm, 6.1% report mild harm, 0.2% report moderate harm and 0.1% report patient death[1].

The data also reveals that about two-thirds of error reports indicate that the error occurred during data entry/order entry/transcribing, about 25% occurred during prescription filling and production, and very few events were reported as occurring during the counseling stage.

The top five most common types of errors (Figure 4) included:

- Wrong patient (2,357) (Above 9% of these reports indicated mild patient harm as a result of the error.)
- Wong quantity (2,148)
- Wrong directions (1,519)
- Wrong drug (1,498)
- Wrong strength (788)

The top five most common contributing factors[2] (Figure 5) included:

- Human factors (1,186)
- Procedure or policy noncompliance (971)
- Training (300)
- Environment/space (198)
- Workflow (189)

Based on information received from ISMP, it appears that 79.9% of pharmacies have registered. Board staff continue to provide education on the legal requirements to report medication errors.

Attachment 2 includes the first report from ISMP documenting information learned through reporting of medication errors to the CAMER system.

c. <u>Petition Requesting Amendment of California Code of Regulations, Title 16, Section 1709.1, Related to Designation of Pharmacist-in-Charge</u>

[1] The report further noted that when reading the event narratives of the reports that were categorized as result in death, however, none actually described patient deaths.

[2] Licensees may select more than one contributing factor.

As you may recall, on October 7, 2025, the Board received a petition requesting the adoption or amendment of a regulation to clarify, California Code of Regulations, title 16, section 1709.1.

Consistent with legal requirements, the Board considered the petition during the November 2025 Board meeting. Following discussion, the Board directed staff to schedule a hearing on the petition.

Following the Board meeting, consistent with legal requirements and with the direction of the Office of Administrative Law, the hearing was scheduled for January 6, 2026 and noticed, and a 45-day written comment period was initiated. On January 5, 2026, the Board received a formal withdrawal of the petition.

Following receipt of the withdrawal, the hearing on the petition was cancelled. No additional action is required.

Attachment 3 includes a copy of the withdrawal notification.

d. Prescriptions and Patients, Addressing Challenges, Finding Opportunities, A Joint Forum on Controlled Substances and Medications for Opioid Use Disorder Access

As previously announced, the California State Board of Pharmacy, along with the Medical Board of California, Osteopathic Medical Board, Board of Registered Nursing, and others hosted a joint forum on December 17, 2025. The event was intended to provide a forum to facilitate better collaboration and understanding specifically related to access to controlled substances. The forum was convened both in person and via WebEx.

The forum included presentations from a variety of agencies, panel discussion, and breakout sessions, with the focus of the breakout sessions on identifying opportunities for health care providers to collaborate to advance patient care.

Information gained during the breakout sessions is being reviewed to determine possible actions that can be taken to help facilitate improved collaboration.

e. Regulations Report

The Board has several regulations in various stages of promulgation. Provided below is the status of the pending regulations.
Note: Regulations being considered by the Board during the meeting are not included below.

1. **California Code of Regulations Section 1746.6, Title 16, Medication Assisted Treatment Protocol**
   Approved by the Board: February 7, 2023
   Current Status: Board staff prepared documents to withdraw the proposed regulations following the enactment of AB 1503 and submitted to DCA Legal on December 11, 2025.

2. **California Code of Regulations Sections, Title 16, 1715, 1715.1, 1735.1, 1736.1, and 1784, Self-Assessments**
   Current Status: Section 100 documents sent to DCA Legal for review on December 3, 2025.

3. **California Code of Regulations Section, Title 16, 1713, Automated Patient Delivery Systems (APDS) Consultation**
   Approved by the Board: April 24, 2024
   Current Status: Approved by the Office of Administrative Law (OAL) on December 23, 2025 with an effective date of April 1, 2026.

4. **California Code of Regulations Section, Title 16, 1708.2, Discontinuance of Business**
   Approved by the Board: February 7, 2023
   Current Status: Approved by OAL on December 23, 2025 with an effective date of April 1, 2026.

5. **California Code of Regulations Section, Title 16, 1707.51, Accessible Prescription Drug Labels**
   Approved by the Board: June 20, 2025
   Current Status: Submitted to DCA for pre-review on October 14, 2025.

6. **California Code of Regulations Section, Title 16, 1717.11, Remote Processing**
   Approved by the Board: November 6, 2025
   Current Status: Noticed to the public by OAL for the 45 day comment period on January 9, 2026 - February 24, 2026.

7. **California Code of Regulations Section, Title 16, 1793.5, Pharmacy Technician Application**
   Approved by the Board: November 6, 2025
   Current Status: Board staff are preparing the documents for the regulations package. Initial meeting with DCA Legal and Budgets scheduled for January 23, 2026.

8. **California Code of Regulations Section, Title 16, 1793.64, Pharmacy Technician Certification Programs**
   Approved by the Board: November 6, 2025
   Current Status: Submitted to DCA for pre-review on November 26, 2025.

9. **California Code of Regulations Section, Title 16, 1710, Hospital Pharmacies Exempt from CAMER**
   Approved by the Board: November 6, 2025
   Current Status: Submitted to DCA for pre-review on December 12, 2025.

10. **California Code of Regulations, Title 16, Sections 1793.7 and 1793.8, Requirements for Pharmacies Employing Pharmacy Technicians in Hospitals with Clinical Pharmacy Programs**
    Approved by the Board: November 6, 2025
    Current Status: Submitted to DCA for pre-review on January 13, 2026.

11. **California Code of Regulations Sections, Title 16, 1746, 1746.1, 1746.2, 1746.3, 1746.4, 1746.5, and 1747, Standard of Care**
    Current Status: Section 100 documents sent to DCA for review on December 9, 2025.

12. **California Code of Regulations Sections, Title 16, 1702, 1702.1, 1706.6, 1730, 1730.1, 1730.2, and 1749, Advanced Pharmacist Practitioners**
    Approved by the Board: November 6, 2025
    Current Status: Submitted to DCA for pre-review on December 29, 2025.

13. **California Code of Regulations Section, Title 16, Sections 1760, Disciplinary Guidelines**
    Current Status: Submitted to DCA for pre-review on December 24, 2025.

Attachment 1

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California State Board of Pharmacy CPJE Statistics
April 1, 2025 – September 30, 2025

The charts below display data for all candidates who took the CPJE examination between April 2025 and September 2025, inclusive.

The Board also displays NAPLEX scores associated with any candidate who took the CPJE during this time period and was reported to the Board, regardless of when the NAPLEX may have been taken (it could have occurred outside the six-month reporting period noted above). Typically, the Board reports CPJE performance data at six-month intervals.

CPJE Overall Pass Rates

Pass/Fail	Frequency	Percent
Fail	651	43.63
Pass	841	56.37
Total	**1492**	**100.00**

NAPLEX Overall Pass Rates

Pass/Fail	Frequency	Percent
E	1	0.11
Fail	156	16.46
Pass	791	83.44
Total	**948**	**100.00**

CPJE Pass Rates – Location by Number

Location	Fail	Pass	Total
California	412	563	975
Other US	206	235	441
Foreign	33	43	76
Total	**651**	**841**	**1492**

CPJE Pass Rates – Location by Percent

Location	Fail	Pass
California	42.26	57.74
Other US	46.71	53.29
Foreign	43.42	56.58

NAPLEX Pass Rates – Location by Number

Location	E	Fail	Pass	Total
California	1	103	423	527
Other US	0	39	319	358
Foreign	0	14	49	63
Total	**1**	**156**	**791**	**948**

NAPLEX Pass Rates – Location by Percent

Location	E	Fail	Pass
California	0.19	19.54	80.27
Other US	0.00	10.89	89.11
Foreign	0.00	22.22	77.78

CPJE Pass Rates – California School of Pharmacy by Number

CA School	Fail	Pass	Total
UCSF	58	62	120
UOP	95	102	197
USC	38	104	142
Western	34	51	85
Loma Linda	11	24	35
UCSD	7	41	48
Touro U	20	29	49
Cal Northstate	34	30	64
Keck	32	21	53
West Coast U	30	22	52
Chapman	24	37	61
CA Health Sci U	6	3	9
Marshall B Ketchum	17	14	31
American U of Health Sciences	2	1	3
U of CA, Irvine School of Pharmacy	4	22	26
Total	**412**	**563**	**975**

CPJE Pass Rates – California School of Pharmacy by Percent

CA School	Fail	Pass
UCSF	48.3	51.7
UOP	48.2	51.8
USC	26.8	73.2
Western	40.0	60.0
Loma Linda	31.4	68.6
UCSD	14.6	85.4
Touro U	40.8	59.2
Cal Northstate	53.1	46.9
Keck	60.4	39.6
West Coast U	57.7	42.3
Chapman	39.3	60.7
CA Health Sci U	66.7	33.3
Marshall B Ketchum	54.8	45.2
American U of Health Sciences	66.7	33.3
U of CA, Irvine School of Pharmacy	15. 4	84.6
Total	**42.3**	**57.7**

NAPLEX Pass Rates – California School of Pharmacy by Number

CA School	E	Fail	Pass	Total
UCSF	0	4	62	66
UOP	0	12	84	96
USC	0	7	55	62
Western	0	8	34	42
Loma Linda	1	3	18	22
UCSD	0	2	17	19
Touro U	0	5	23	28
Cal Northstate	0	21	18	39
Keck	0	7	28	35
West Coast U	0	17	18	35
Chapman	0	6	26	32
CA Health Sci U	0	4	5	9
Marshall B Ketchum	0	5	14	19
American U of Health Sciences	0	2	1	3
U of CA, Irvine School of Pharmacy	0	0	20	20
Total	**1**	**103**	**423**	**527**

NAPLEX Pass Rates – California School of Pharmacy by Percent

CA School	E	Fail	Pass
UCSF	0.0	6.1	93.9
UOP	0.0	12.5	87.5
USC	0.0	11.3	88.7
Western	0.0	19.0	81.0
Loma Linda	4.5	13.6	81.8
UCSD	0.0	10.5	89.5
Touro U	0.0	17. 9	82.1
Cal Northstate	0.0	53.8	46. 2
Keck	0.0	20.0	80.0
West Coast U	0.0	48.6	51.4
Chapman	0.0	18.8	81.3
CA Health Sci U	0.0	44.4	55. 6
Marshall B Ketchum	0.0	26.3	73.7
American U of Health Sciences	0.0	66. 7	33.3
U of CA, Irvine School of Pharmacy	0.0	0.0	100.0
Total	**0.2**	**19.5**	**80.3**

CPJE Pass Rates – School of Pharmacy by Number

School	F	P	Total
AUBURN	1	0	1
U OF AZ	1	4	5
U OF AR	1	0	1
UCSF	58	62	120
U OF PACIFIC	95	102	197
USC	38	104	142
U OF CO	5	6	11
U OF CONN	0	1	1
HOWARD DC	1	1	2
FL A&M	1	2	3
U OF FL	2	5	7
MERCER	0	2	2
U OF GA	1	2	3
IDAHO SU	0	1	1
U OF IL CHI	2	9	11
BUTLER U	2	1	3
PURDUE	3	2	5
DRAKE	0	1	1
U OF IA	1	2	3
U OF KS	3	4	7
U OF KY	1	4	5
NE LA U	0	2	2
XAVIER	4	0	4
U OF MD	2	2	4
MA COL PHARM	12	10	22
NE-MA	2	9	11
FERRIS	1	2	3
U OF MI	2	2	4
WAYNE SU	0	1	1
U OF MN	2	1	3
ST. LOUIS COL OF PH	4	1	5
UMKC	1	0	1
U OF MT	1	1	2
CREIGHTON	2	6	7
RUTGERS	2	2	4
U OF NM	4	3	7
WESTERN	34	51	85
MIDWESTERN U CHICAGO	2	5	7
A&M SCHWARTZ	4	2	6
ST. JOHNS	6	6	12
SUNY-BUFF	3	2	5
UNION U	0	3	3
UNC	6	7	13
ND SU	0	1	1

OH NRTHRN U	0	2	2
OH STATE U	4	2	6
U OF CINN	0	1	1
U OF TOLEDO	1	1	2
OR STATE U	1	2	3
DUQUESNE	0	1	1
PHL C OF PHARM	1	1	2
TEMPLE	0	2	2
U OF PITT	0	3	3
U OF RI	4	1	5
MED U OF SC	1	0	1
U OF TN	3	4	7
TX SO U	4	1	5
U OF HOUS	2	2	4
U OF TX	4	3	7
U OF UT	0	3	3
MED C OF VA	0	2	2
U OF WA	9	10	19
WA STATE U	7	2	9
U OF WI-MAD	6	4	10
U OF WY	0	1	1
CAMPBELL U	0	1	1
NOVA SOUTHEASTERN	3	2	5
WILKES UNIVERSITY	0	2	2
TEXAS TECH	3	1	4
BERNARD J DUNN	1	0	1
MIDWESTERN AZ	9	9	18
NEVADA COLLEGE OF PHARM	14	10	24
LOMA LINDA	11	24	35
UCSD	7	41	48
MA SCHOOL OF PHARM - WORCESTER	5	6	11
PALM BEACH ATLANTIC UNIVERSITY	0	2	2
LAKE ERIE COL	1	5	6
TOURO U	20	29	49
PAC U OF OR	10	10	20
U OF FINDLAY	0	1	1
U OF INCARNATE WORD	1	1	2
CAL NORTHSTATE	34	30	64
OTHER/FG	33	43	76
U OF HI - HILO	5	4	9
TEXAS A&M	0	1	1
THOMAS JEFFERSON U	1	1	2
BELMONT U	1	0	1
HARDING U	2	1	3
APPALACHIAN COLLEGE OF PHARM	1	0	1
LIPSCOMB U	1	2	3
CHICAGO ST U	1	1	2

U OF NEW ENGLAND	1	0	1
REGIS UNIVERSITY	2	0	2
EAST TENNESSEE STATE U	1	0	1
ST. JOHN FISHER	0	3	3
ROSALIND FRANKLIN U	0	1	1
WESTERN NE U	1	1	2
U OF ST JOSEPH	2	0	2
ROOSEVELT U	1	0	1
SOUTH COLLEGE	0	2	2
U OF SOUTH FLORIDA	3	0	3
KECK GRAD INST SCHL PHARM	32	21	53
CA HEALTH SCI U	6	3	9
U OF THE SCIENCES	1	1	2
UNTX COL OF PHARM	3	2	5
WEST CST UNIV COL PHARM	30	22	52
CHAPMAN U SCHL PHARM	24	37	61
MARSHALL B KETCHUM U	17	14	31
AMERICAN UNIVERSITY OF HEALTH SCIENCES	2	1	3
BINGHAMTON UNIVERSITY OF NY SCHOOL OF PHARMACY & PHARM SCIENCES	0	2	2
U OF CA, IRVINE SCHOOL OF PHARMACY	4	22	26
Total	**651**	**841**	**1492**

CPJE Pass Rates – Country by Number

Country	Fail	Pass	Total
ARMENIA	1	2	3
AUSTRALIA	0	1	1
CANADA	0	3	3
EGYPT	9	17	26
SPAIN	1	1	2
INDIA	2	2	4
IRAQ	0	2	2
IRAN	1	3	4
JORDAN	1	5	6
LEBANON	0	1	1
NIGERIA/NEW GUINEA	2	1	3
PHILIPPINES	12	3	15
PAKISTAN	2	1	3
SYRIA	1	1	2
USA	619	798	1417
Total	**651**	**841**	**1492**

CPJE Pass Rates – CA School of Pharmacy by First-Time and Multiple-Time Test Takers

School				First	Multiple	Total
UCSF	JPE P/F	PASS	COUNT	44	18	62
			%	53.66	47.37	51.67
		FAIL	COUNT	38	20	58
			%	46.34	52.63	48.33
UOP	JPE P/F	PASS	COUNT	87	15	102
			%	55.06	38.46	51.78
		FAIL	COUNT	71	24	95
			%	44.94	61.54	48.22
USC	JPE P/F	PASS	COUNT	94	10	104
			%	77.05	50.00	73.24
		FAIL	COUNT	28	10	38
			%	22.95	50.00	26.76
WESTERN	JPE P/F	PASS	COUNT	49	2	51
			%	69.01	15.38	60.00
		FAIL	COUNT	23	11	34
			%	32.39	84.62	40.00
LOMA LINDA	JPE P/F	PASS	COUNT	19	5	24
			%	76	50.00	68.57
		FAIL	COUNT	6	5	11
			%	24	50.00	31.43
UCSD	JPE P/F	PASS	COUNT	39	2	41
			%	84.78	100.00	85.42
		FAIL	COUNT	7	0	7
			%	15.22	0.00	14.58
TOURO U	JPE P/F	PASS	COUNT	23	6	29
			%	62.16	50.00	59.18
		FAIL	COUNT	14	6	20
			%	37.84	50.00	40.82
CAL NORTHSTATE	JPE P/F	PASS	COUNT	25	5	30
			%	53.19	29.41	46.88
		FAIL	COUNT	22	12	34
			%	46.81	70.59	53.13
KECK	JPE P/F	PASS	COUNT	17	4	21
			%	47.22	23.53	39.62
		FAIL	COUNT	19	13	32
			%	52.78	76.47	60.38
WEST COAST U	JPE P/F	PASS	COUNT	16	6	22
			%	57.14	25.00	42.31
		FAIL	COUNT	12	18	30
			%	42.86	75.00	57.69
CHAPMAN	JPE P/F	PASS	COUNT	36	1	37
			%	73.47	8.33	60.66

School				First	Multiple	Total
		FAIL	COUNT	13	11	24
			%	26.53	91.67	39.34
CA HEALTH SCI U	JPE P/F	PASS	COUNT	0	3	3
			%	0.00	37.50	33.33
		FAIL	COUNT	1	5	6
			%	100.00	62.50	66.67
MARSHALL B KETCHUM U	JPE P/F	PASS	COUNT	14	0	14
			%	66.67	0.00	45.16
		FAIL	COUNT	7	10	17
			%	33.33	100.00	54.84
AMERICAN UNIVERSITY OF HEALTH SCIENCES	JPE P/F	PASS	COUNT	1	0	1
			%	33.33	0.00	33.33
		FAIL	COUNT	2	0	2
			%	66.67	0.00	66.67
U OF CA, IRVINE SCHOOL OF PHARMACY	JPE P/F	PASS	COUNT	21	1	22
			%	84.00	100.00	84.62
		FAIL	COUNT	4	0	4
			%	16.00	0.00	15.38
Total	JPE P/F	PASS	COUNT	**485**	**78**	**563**
			%	**64.49**	**34.98**	**57.74**
		FAIL	COUNT	**267**	**145**	**412**
			%	**35.51**	**65.02**	**42.26**

Attachment 2

Semi-Annual Report
June – December 2025*

California Medication Error Reporting Program (CAMER)

Prepared for

California Board of Pharmacy

Prepared by

Institute for Safe Medication Practices

January 2026

* Licensees were required to report medication errors that occurred on or after September 1, 2025

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Background

Business and Professions Code (BPC) section 4113.1 establishes requirements for a community pharmacy to report medication errors to an entity approved by the California Board of Pharmacy. The statute requiring medication error reporting can be viewed at BPC section 4113.1.

In September 2024, after a competitive bidding process, the Board approved the Institute for Safe Medication Practices (ISMP), an ECRI Company, as the entity to receive and review medication error reports under BPC section 4113.1.

The Board established that medication errors that occur on or after September 1, 2025, must be reported to the CAMER system in accordance with the established legal requirements.

On June 30, 2025, the California Medication Error Reporting (CAMER) system portal went live, allowing required pharmacies to report medication errors pursuant to BPC section 4113.1. This report provides analysis of data collected from June 30, 2025, through December 31, 2025. However, please note that licensees were required to report medication errors that occurred on or after September 1, 2025

Overall Reporting

Total Number of Reports

For the reporting period June – December 2025, a total of 9,653 reports were submitted by licensees, with the reporting volume increasing each month (**Figure 1**). The reports were submitted by 2,536 (47.3%) of the 5,361 pharmacies registered with the CAMER system. There was a notable rise in reporting volume beginning on the compliance date of September 1, 2025. No reports were submitted on June 30, 2025, the day the reporting system went live. The first report was received on July 16, 2025.

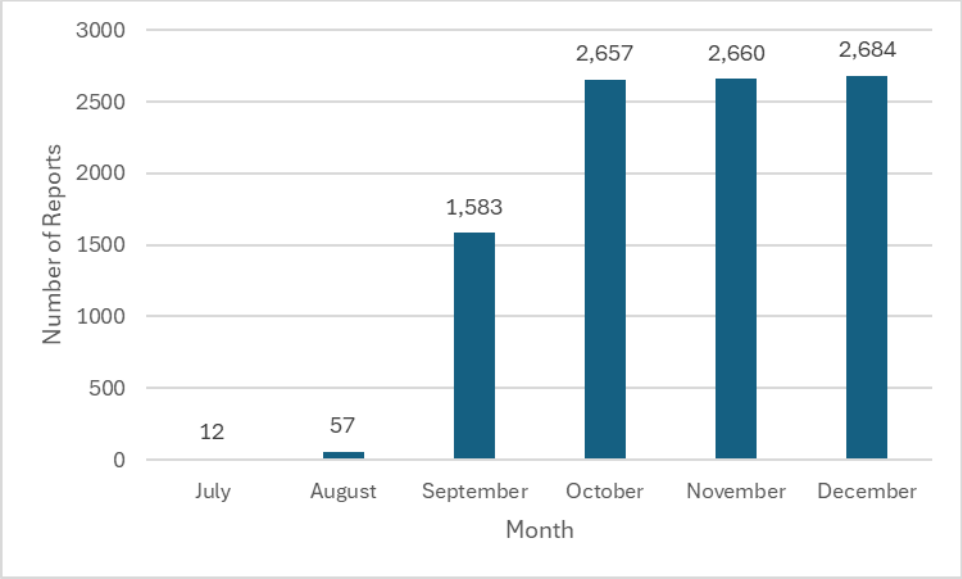

Figure 1. Reports submitted by month, July – December 2025 (N = 9,653). Note: The reports were submitted by 2,536 (47.3%) of the 5,361 pharmacies registered with the CAMER system.

Reports by Pharmacy Type

Reports were submitted by a total of 2,468 pharmacies. Most reports were submitted by community chain pharmacies (N = 6,352) (**Table 1**).

Table 1. Reports submitted by pharmacy type, July – December 2025 (N = 9,653).

Pharmacy type	Number of reports
Community chain pharmacy	6,352
Non-chain community pharmacy	1,449
Mail-order pharmacy	897
Closed-door pharmacy	568
Specialty pharmacy	266
Hospital outpatient pharmacy	121

Reports by Harm Score

Licensees are required to submit harm scores using the Agency for Healthcare Research and Quality's (AHRQ) harm scale. More than 90% (93.6%, n = 9,031) of events were reported as not resulting in patient harm (**Table 2**). Six (0.1%) reports were categorized as resulting in death; however, when reading the event narratives, none described patient deaths.

Prescription sold to wrong patient. Patient has not started medication. Patient would return it to prescription to pharmacy.

Patient was given a 10 mL size bottle instead of 4x1 mL bottle. Error occurred as pharmacist bypassed the computer scanning by manually typing in the NDC [National Drug Code] of the

medication. Pharmacist also failed to double check the medication during counselling when they picked up the medication. Called MD [physician] and patient. MD aware and is fine with it.

Also, it appears that two events were reported twice, inflating the number of reports with the harm score of death. The repeated events were the following:

Patient brought the prescription vial with mixed 2 strength amoxicillin 500 mg and 875 mg. Patient took some amoxicillin 875 mg and realized there was mix of 2 strengths (same color).

XXXXX XXXXX received Sublocade injection on XXXXX. I gave him the shot , not seeing the special needle that was supposed to be used with the injection. I then realized that the solution is very thick and that the injection requires a bigger needle. Saw the needle provided from the manufacturer, gave him the injection. Patient called the clinical service manager and stated that I used [more than one] needle.

Table 2. Agency for Healthcare Research and Quality (AHRQ) harm score associated with reported events, July – December 2025 (N = 9,653).

Agency for Healthcare Research and Quality (AHRQ) Harm Score	Number of Reports	Percentage of reports
No Harm	9,031	93.6%
Mild Harm	589	6.1%
Moderate Harm	224	0.2%
Severe Harm	3	0.0%
Death	6	0.1%

One of the reported events resulting in severe harm involved the failure to properly reconstitute a bottle of Firvanq (vancomycin for oral solution). An alert regarding this event was published by the Board in the **November 2025 issue of The Script**.

In another report, the omission of a patient's antiseizure medications resulted in the patient experiencing seizures and being admitted to the emergency department (ED).

A [controlled] medication was withheld from a patient since the doctor was from another state (XXXXX) and did not have a DEA license for the state which our pharmacy is located (XXXXX). The medications withheld are Lacosamide 100 mg tab (1 tab PO BID) and Peramphanel 2 mg tab (1 tab PO QHS). The pharmacist verifying prescriptions informed the pharmacy manager, and the pharmacy manager deferred to this pharmacist's judgement. Because of this incident, the patient developed seizures and had to be admitted to the ED. This event occurred due to confusion about the laws regarding [controlled substance] prescriptions from out of state. There was a confusion that [controlled substance] prescriptions from our of state prescribers could only be filled if they had an in-state DEA license.

Licensees also have the option to include a harm score using the scale published by the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) (**Figure 2**). Only 1,089 reports included answers to this optional question.

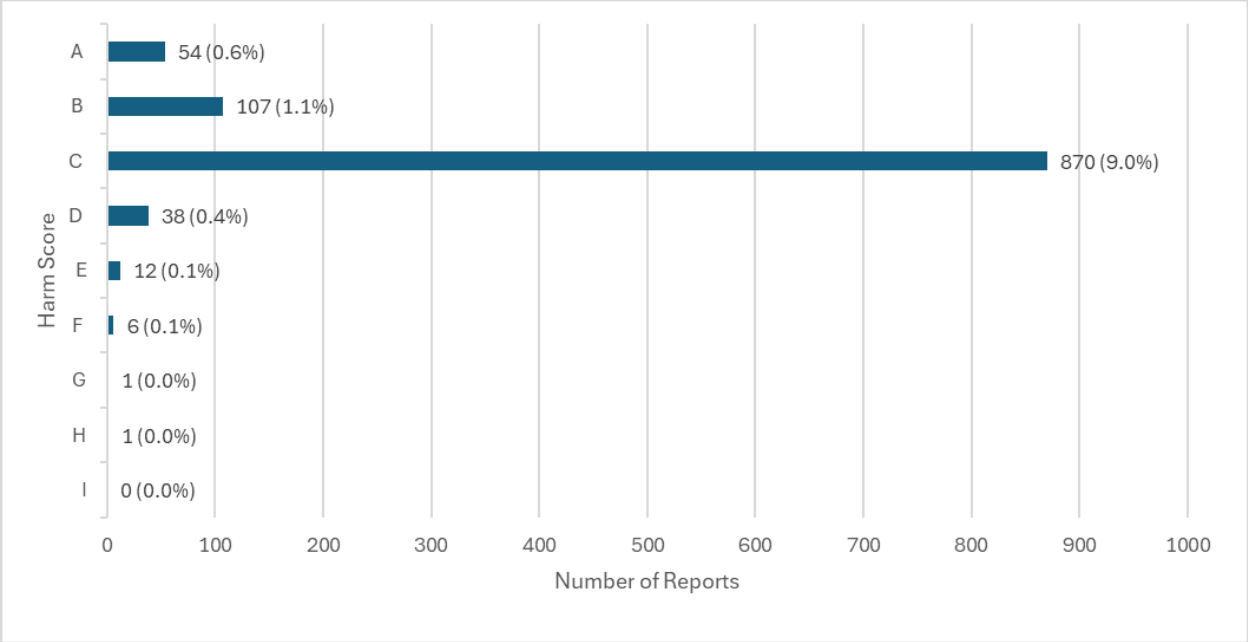

Figure 2. National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) harm score associated with reported events, July – December 2025 (N = 9,653). Note: Licencees are not required to report a harm score using the NCCMERP scale. Only those reports that included a NCCMERP harm score are displayed (n = 1,098 of 9,653). See Appendix A for the full definitions of the NCCMERP harm scores.

Similar to the AHRQ harm score data, most reports that included a NCCMERP harm score indicated the events reached patients but did not result in harm (harm scores C and D). However, the NCCMERP harm score scale allows licensees to indicate that an event did not actually reach patients. This is different than the AHRQ harm score scale which only categorizes events that reach patients. Licensees used the NCCMERP harm score scale to indicate that 1.7% (n = 161 of 9653) did not reach patients (harm scores A and B). For example:

Prescription was filled under the wrong patient name. It was delivered to a facility but not dispensed to patient.

Medication Cefazolin was filled instead of Ceftriaxone but not given to patient.

Nurse from facility called. Januvia100 mg dose was delivered instead of 25 mg. The wrong strength medication was never administered to the patient.

Wrong strength of controlled substance was verified and dispensed to facility. Nurse discovered it before administration to pt. Therefore, patient was not given this medication.

When analyzing the event narratives, licensees incorrectly assigned the NCCMERP harm score A and B (events that did not reach patients) to events that reached patients, including omissions. For example:

We had missed sending supplies of alcohol pads, syringes, and needles for a patient on Procrit.

A prescription for Olmesartan 5 mg tablets was dispensed and given to the patient incomplete instructions. The original electronic prescription instructions were "Take 1 tablet by mouth." Pharmacist entered take 1 tablet by mouth as directed as directed.

HIPAA breach with a printed hard copy got bagged in the incorrect patient bag no drugs was delivered just prescription hard copy.

Also, discrepancies were noted in a limited number of reports that included both the AHRQ and NCCMERP harm scores. In two cases, licensees provided a more severe AHRQ harm score (i.e., moderate harm) than the NCCMERP harm score (i.e., D - an error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm). The two event narratives are below:

Dispensed dose#1 700mg instead of 350mg.

Patient's daughter/caregiver was picking up a group of medications for patient, including Xarelto 2.5 mg. Per the daughter it was a busy afternoon, and the pharmacy clerk/cashier seemed irritated and frustrated not being able to find everything. Daughter tried to suggest something and was rudely told "I know what I'm doing." Daughter waited for the Xarelto. The Xarelto given was not Xarelto 2.5 mg but Xarelto 20 mg. Discovered this on XX/XX/XX when patient via caregiver asked when they could refill Xarelto. Upon investigation, patient said bottle only had 30 tablets in it. PIC [pharmacist in charge] further inquired if it was a stock bottle or in a vial. Finally discovered when we asked caregiver to show us the bottle and turned out the label for Xarelto 2.5 mg was affixed to a stock bottle of Xarelto 20 mg. Caregiver was only giving patient one tablet per day, vs. the direction on the bottle of 2.5 mg twice daily. Patient had already taken 24 tablets of the 20 mg by date of discovery. PIC interviewed both patient and daughter/caregiver and was initially told that patient had no extra bruising but mentioned a fall but not really any bruising. However, upon discussing with the prescriber's representative, patient reported the fall (no date specified) and that there was bruising on the arm. XXXXXX pointed out that this is the 2nd blood thinner for the pt, confirmed by the pt's profile at pharmacy database.

In another event report, the licensee submitted an AHRQ harm score of "no harm" but also the NCCMERP harm score G (an error occurred that may have contributed to or resulted in permanent patient harm). The event description (see below) does not describe the patient's outcome, so it is not possible to determine which harm score is most appropriate. However, based on events submitted to ISMP's reporting programs, a mix-up between conventional and liposomal amphotericin B that reaches a patient can result in serious harm, including death, or subtherapeutic treatment as the dosing of the products are different.

An error occurred in which conventional Amphotericin B was dispensed instead of the intended liposomal Amphotericin B (Generic for AmBisome). Upon investigation, the following findings were documented: The pharmacist recognized that the initially selected medication was incorrect and proactively requested the typist to update the system to reflect the correct NDC for liposomal Amphotericin B. Although the system was updated to the correct NDC, the label used to fill the medication remained unchanged, and the product was dispensed using the previous label linked to the conventional formulation. The pharmacist was unaware of the visual and packaging differences between the conventional and liposomal formulations. The pharmacist assumed that the updated

NDC corresponded to a generic equivalent of AmBisome, leading to a misinterpretation of the product identity.

Reports by Stage of the Dispensing Process

More than two-thirds (36.2%, n = 2,399) events occurred during data entry/order entry/transcribing with another quarter (25.4%, n = 2,452) occurring during prescription filling/production. Very few (0.3%, n = 27) events were reported as occurring during the counseling stage (**Figure 3**).

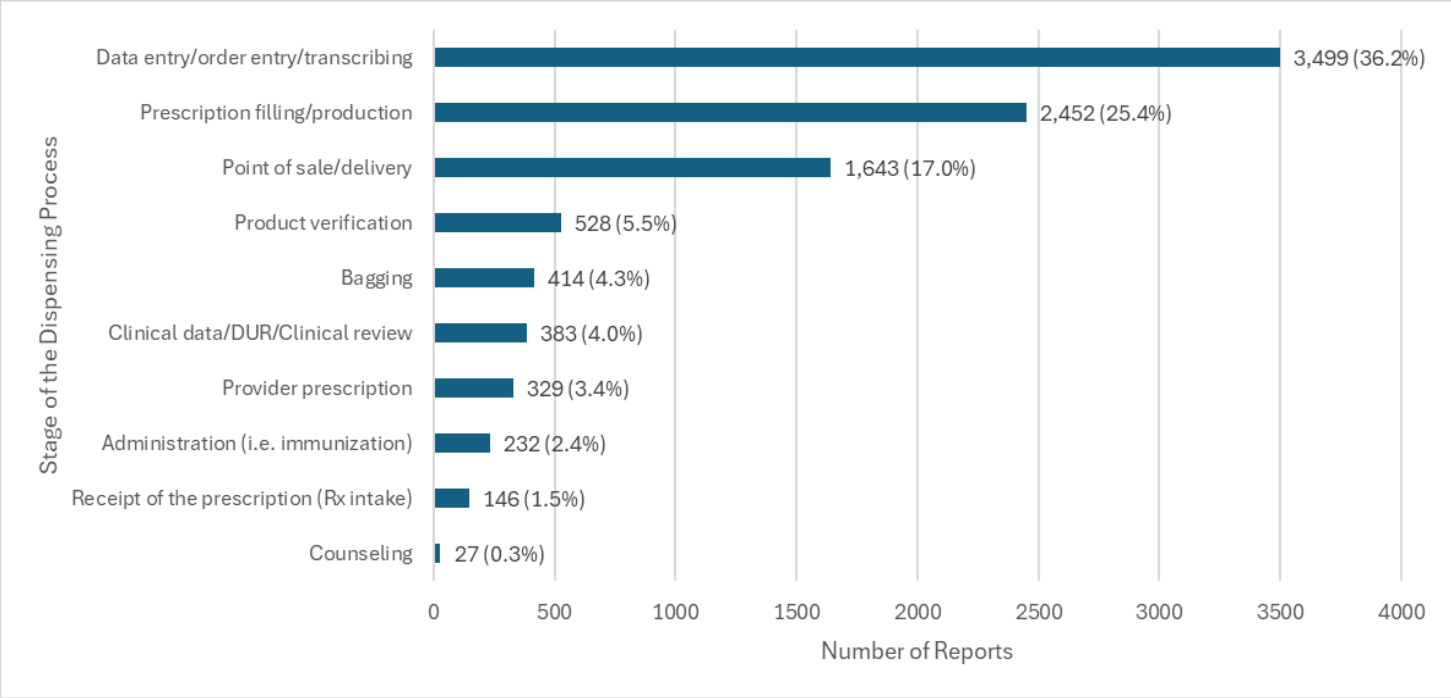

Figure 3. Stages of the dispensing error in which the error occurred, July – December 2025 (N = 9,653).

Reports by Patient Age

The majority of reported events involved adult (56.8%, n = 5,481) and older adult (33.9%, n = 3,274) patients. (**Table 3**).

Table 3. Age of patients involved in reported events, July – December 2025 (N = 9,653).

Patient Age	Number of Reports	Percentage of reports
Birth to 1 month	26	0.3%
Greater than 1 month to 1 year	53	0.5%
Greater than 1 year to 12 years	577	6.0%
Greater than 12 years to 17 years	242	2.5%
Greater than 17 years to 65 years	5,481	56.8%
Greater than 65 years	3,274	33.9%

When looking at patients between birth and 1 year of age, one event resulted in moderate harm:

The patient was prescribed enoxaparin 30 mg/0.3 mL, with instructions to inject 0.08 mL subcutaneously every 12 hours for nine days. The prescription was intended to be prepared as a compounded product in individually dosed syringes. However, the compounded NDC does not exist in the pharmacy system, and only the commercially available 30 mg/0.3 mL NDC is active in the system. During data verification, the pharmacist contacted the prescriber to confirm the prescription, quantity, and directions. There was a miscommunication amongst the prescriber, inpatient pharmacy, and outpatient pharmacy regarding which department would prepare the compounded syringes. The outpatient pharmacist understood that inpatient pharmacy would prepare the 0.08 mL syringes and deliver them for dispensing. The prescription was released for label generation and delivery to inpatient pharmacy. However, the prescription was filled using commercially available 30 mg/0.3 mL syringes, which were scanned, verified, and dispensed without compounding or volume adjustment. As a result, the patient received the full 30 mg dose instead of the intended 8 mg dose.

Reports by Pharmacy Staffing

The CAMER reporting portal includes an optional question regarding pharmacy staffing at the time of the event. Fewer than 13% (12.6%, n = 1,216 of 9,653) of reports included responses to this question (**Table 4**). Of those reports that included a response to this question, 83.3 % (n = 1,013 of 1,216) indicated the event occurred during a time when the pharmacy was operating with regular staffing. More than 15% (15.5%, n =188 of 1,216) of reports indicated the pharmacy was operating with less than usual staffing.

Table 4. Pharmacy staffing level at the time of the event, July – December 2025 (N = 1,216).

Staffing Level	Number of Reports	Percentage of reports
Regular staffing	1,013	83.3%
Less than usual staffing	188	15.5%
Other	8	0.7%
More than usual staffing	7	0.6%

Wrong strength (24.5%, n = 46 of 188), wrong quantity (15.4%, n = 29 of 188), and wrong patient (15.4%, n – 29 of 188) errors were the top three types of events that occurred during times of less than usual staffing. These same event types appear in the overall top 5 reported event types (**Figure 4** below), although in different order.

Reporting by Event Type

The breakdown of the data by event type is presented in **Figure 4**. Almost a quarter (24.4%, n = 2,357) of the events were wrong patient errors. ISMP also sees this as one of the most frequently reported events to ISMP from community pharmacies and consumers.

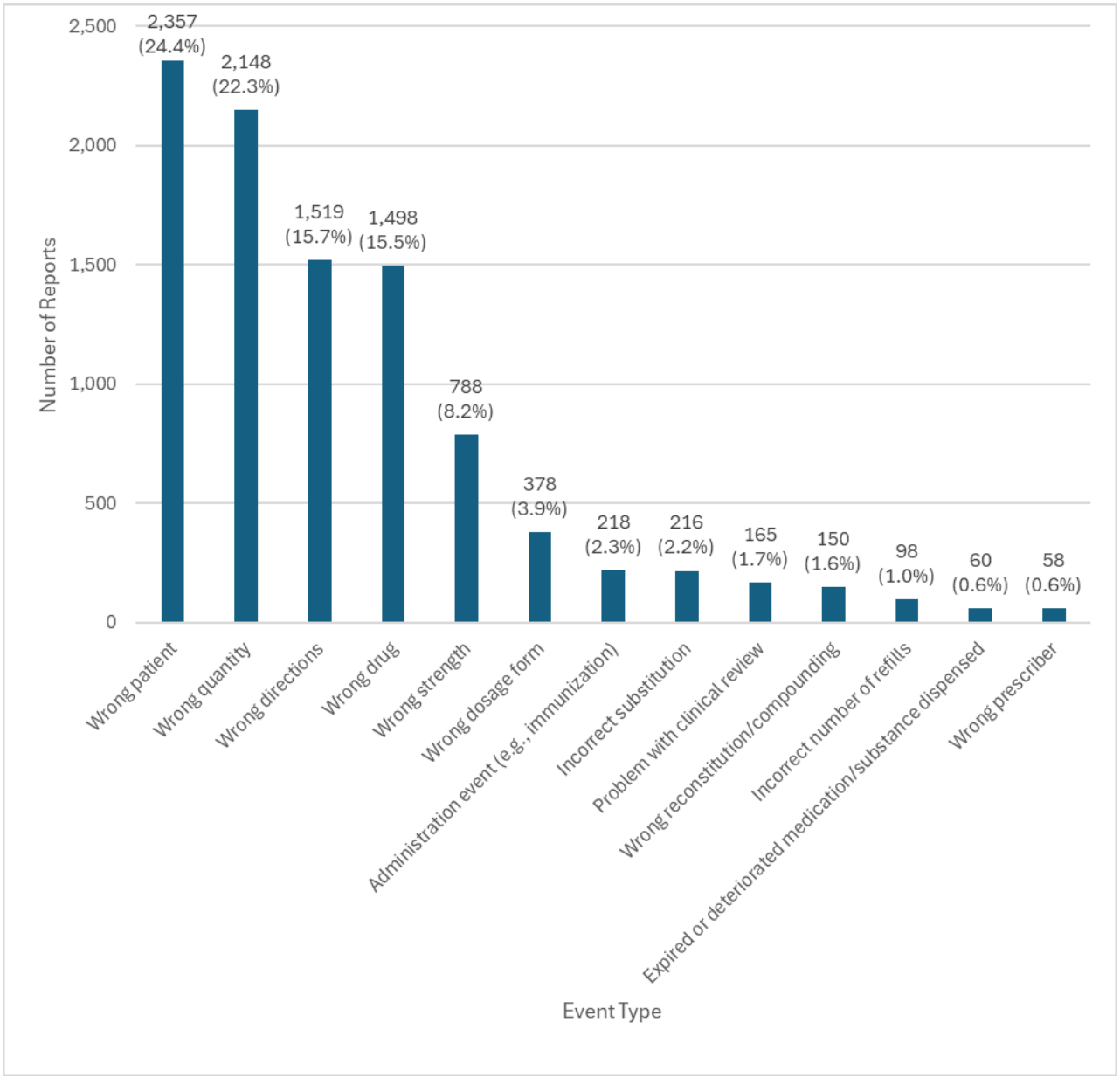

Figure 4. Reported events by event type, July – December 2025 (N = 9,653).

Wrong Patient Errors

Types of Wrong Patient Errors

Wrong patient errors can happen for various reasons and at different stages of the medication use process. The CAMER systems allows licensees the option (i.e., not a required question) to select a second level event type for wrong patient errors (**Table 5**). The most frequently reported type of wrong patient error was giving the customer the wrong patient's bag. This often happens when a pharmacy staff member selects the wrong patient's bag from the will call area. The process of identifying the patient can be flawed if two identifiers such as the patient's full name and date of birth are not asked and provided at the point-of-sale. Some pharmacy staff believe they know their

patients by sight and have not developed the safe habit of always asking patients to state their full name and date of birth. Or, caregivers, friends, and family members who pick up prescriptions for the patient may not know the patient's date of birth. Thus, the wrong patient's bag may be chosen if there are medications in the will call area for patients with a similar or the same last name.

Table 5 Second level event types associated with wrong patient error as selected by licensees, July – December 2025 (N = 2,357)

Type of wrong patient error	Number of Reports	Percentage of reports
Wrong patient bag given to customer	126	5.3%
Prescription placed into wrong customer's bag	68	2.9%
Wrong patient selected in the computer system	33	1.4%
Wrong patient label applied to medication container	8	0.3%

Licensees also reported placing a prescription in the wrong patient's bag. Analysis of events has identified that these errors often stem from working on more than one patient's prescription at a time, and then placing the patient's medication in a bag intended for another patient. Most people pick up their medication and leave the pharmacy without ever opening the bag.

Patient Harm Associated with Wrong Patient Errors

Wrong patient errors can have serious consequences. These include a patient taking a contraindicated medication, omission of the correct medication, misuse of the incorrect medication, which may result in the patient experiencing serious adverse effects, and a breach of protected health information. Most (90.75%; n = 2,139) reported wrong patient errors did not result in patient harm (**Table 6**). There was one report categorized as a patient death, but the event description (*Prescription sold to wrong patient. patient has not started medication. Patient would return it to prescription to pharmacy.*) did not indicate the patient died and provided insufficient detail to fully analyze.

Table 6. Agency for Healthcare Research and Quality (AHRQ) harm score associated with wrong patient errors, July – December 2025 (N = 2,357)

Agency for Healthcare Research and Quality (AHRQ) Harm Score	Number of Reports	Percentage of reports
No Harm	2,139	90.75%
Mild Harm	215	9.12%
Moderate Harm	2	0.08%
Severe Harm	0	0.0%
Death	1	0.04%

One event that resulted in moderate harm involved an adult patient (greater than 17 years to 65 years of age) who was given a different patient's prescription for Mounjaro (tirzepatide), a glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults

and pediatric patients 10 years of age and older with type 2 diabetes mellitus. The event narrative is below:

Patient's spouse XXXXX notified us that patient has received a wrong person's medication. [Patient 1] was supposed to receive Mounjaro 5 mg, but we dispensed [Patient 2's] Mounjaro 15 mg. He already injected one dose as soon as the medication was received. Pharmacist on duty advised to stop using the 15 mg immediately and counseled on possible side effects, including vomiting, diarrhea, and hypoglycemia. Caregiver will keep a close eye on the patient. We dispensed the correct medication for [Patient 1] and reprocessed the prescription for [Patient 2]. [Patient 1's] spouse informed the pharmacist that patient started throwing up. Will advise the patient to contact his PCP [primary care provider] if side effects such as palpitations, low sugar level occur. Advised to avoid any additional doses for at least two weeks.

The other event that resulted in moderate harm involved an older adult (greater than 65 years of age). The patient received a prescription for donepezil, which is used for the treatment of dementia of the Alzheimer's type, intended for a different patient. The event narrative is below:

Patients daughter came into the pharmacy on Thursday, XXXXX XX, 2025. She stated that her mother came to pick up a prescription on Tuesday, XXXXX X, 2025 [seven days earlier] but was handed a different patient's prescription. She took the medication and went to the hospital on Wednesday, XXXXX X, 2025 [the next day] because she felt unwell.

Contributing Factors

Licensees can select multiple contributing factors associated with an event (**Figure 5**). Human factors (50.3%, n = 1,186), the interaction between humans, the systems they use, and the environments in which they work, was the most frequently recorded contributing factor followed by procedure/policy non-compliance (41.2%, n = 971) competency and knowledge, cognitive burden, fatigue, emotional stress, lack of motivation, staffing, workload, physical environment, resource management, and poor communication play a key role in medication errors.

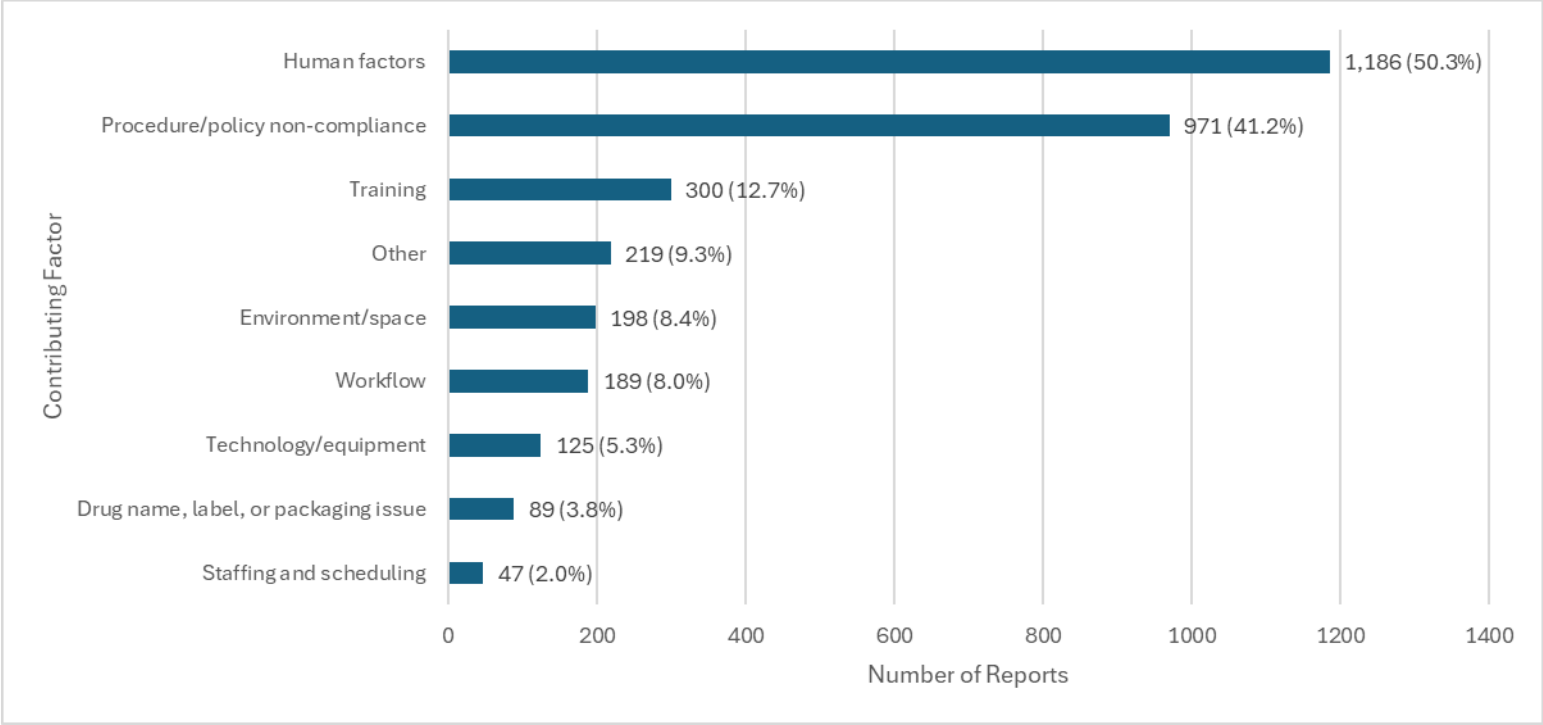

Figure 5. Factors reported as contributing to wrong patient errors, July – December 2025 (N = 2,357). Note: Licensees may select more than one contributing factor.

Licensees may also answer an optional question regarding pharmacy staffing at the time of the event. For wrong patient errors, only 9.7% (n = 229 of 2,357) of reports included an answer for this question. The majority indicated that the event occurred at a time with regular staffing (85.6%, n = 196 of 229) or more staffing than usual (0.9%, n = 2 of 229). Only 12.7% (n = 29 of 229) of the reports indicated the event occurred at a time with less than usual staffing. This appears to be consistent with only 47 (2.0%) of reports indicating that staffing and scheduling contributed to the reported event (**Figure 5**)

Stage of the Dispensing Process

Sixty percent (n = 1,420) of reports (**Figure 6**) indicate the wrong patient error occurred during the point of sale/delivery stage of the dispensing process. This is consistent with the finding that more licensees indicated that the type of wrong patient error was the wrong patient bag being given to the customer (**Table 5**).

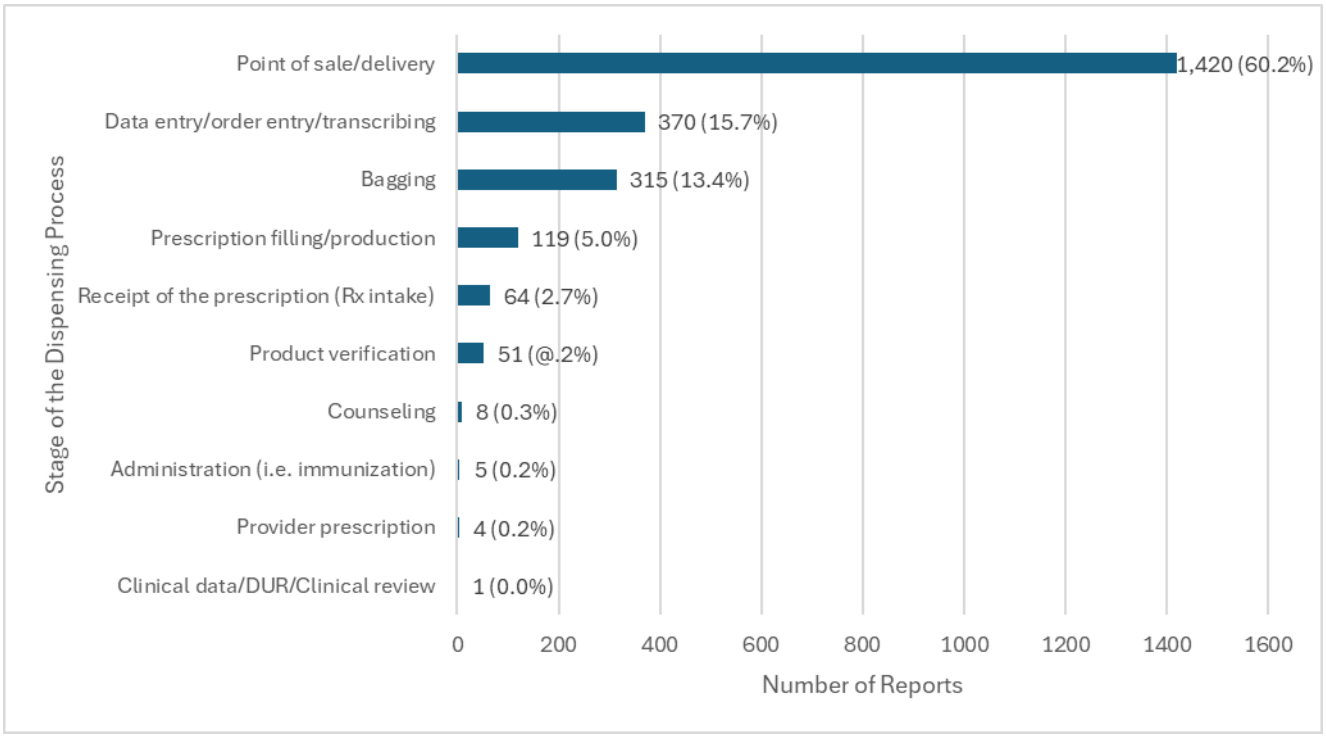

Figure 6. Stages of the dispensing error in which the in wrong patient error occurred, July – December 2025 (N = 2,357).

The next three most frequently reported stages of the reporting process were data/entry/order entry/transcribing (15.7%, n = 370), bagging (13.4%, n = 315), and prescription filling/production (5.0%, n = 119). These findings are also consistent with the types of wrong patient error reported (**Table 5**). For example, placing a prescription in the wrong customer's bag typically occurs during the bagging stage. Also, selecting the wrong patient in the computer system would most often occur during data/entry/order entry/transcribing or at the point of sale when looking a patient up to retrieve their completed prescriptions. And, finally, applying the wrong patient label to a medication container occurs during filling/production.

Patient Demographics Related to Wrong Patient Errors

Reported wrong patient events occurred across the spectrum of patient age (**Figure 7**), sex (**Figure 8**), and insurance status (**Figure 9**). When analyzing the insurance "other" data, 1.4% (n = 34) reports indicated the patient paid with cash.

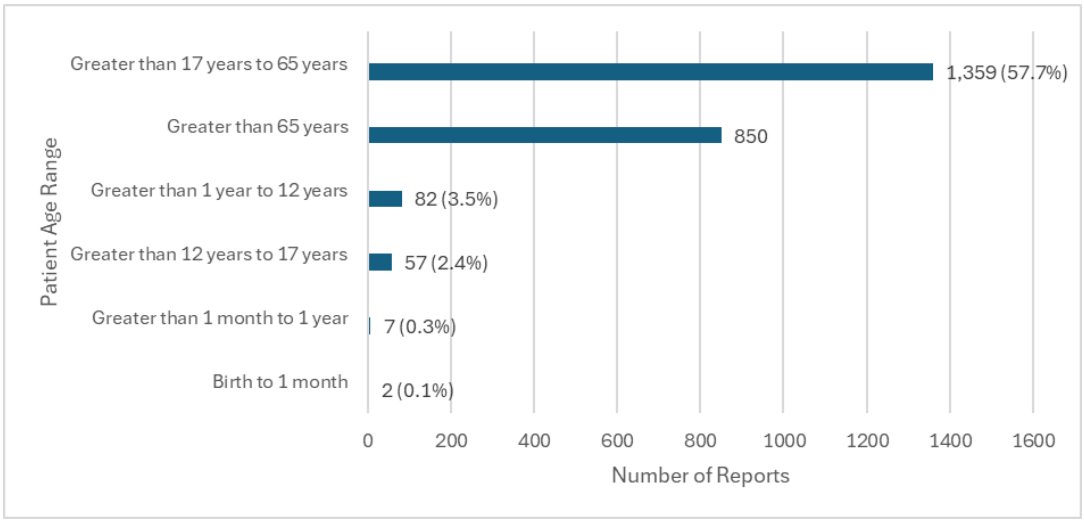

Figure 7. Patient age reported in wrong patient errors, July – December 2025 (N = 2,357).

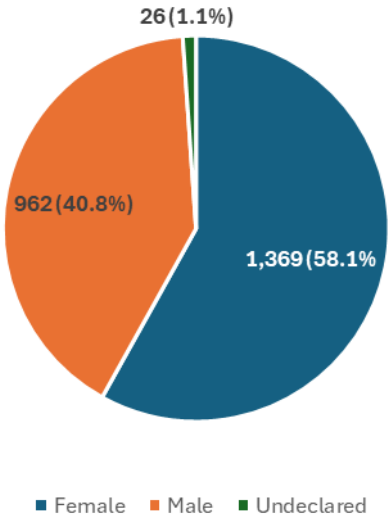

Figure 8. Patient sex reported in wrong patient errors, July – December 2025 (N = 2,357).

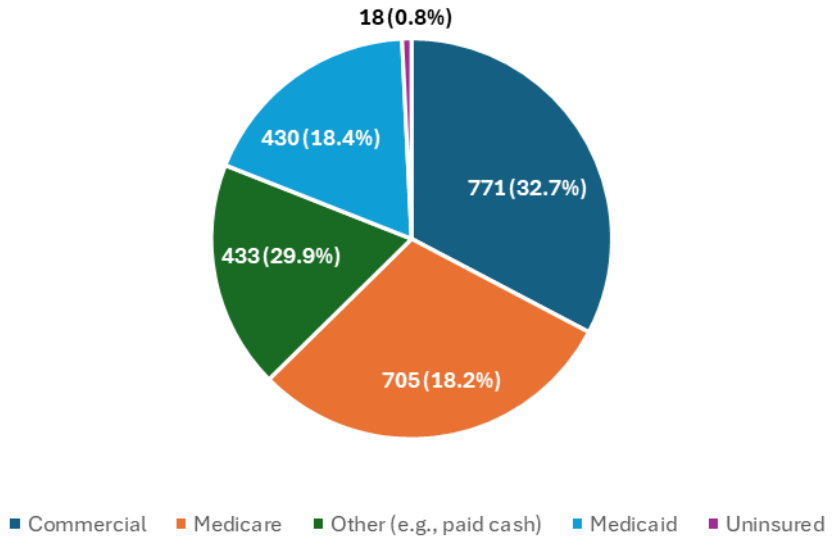

Figure 9. Patient insurance type reported in wrong patient errors, July – December 2025 (N = 2,357).

Medications Involved in Wrong Patient Errors

Figure 10 lists the 10 most commonly reported medications involved in wrong patient errors. The most common medication involved with wrong patient errors was atorvastatin (3.5%, n = 83), an HMG-CoA reductase inhibitor. No individual high-alert medication (a drug that bears a heightened risk of causing significant patient harm when they are used in error) appears in the 10 most commonly reported medications.

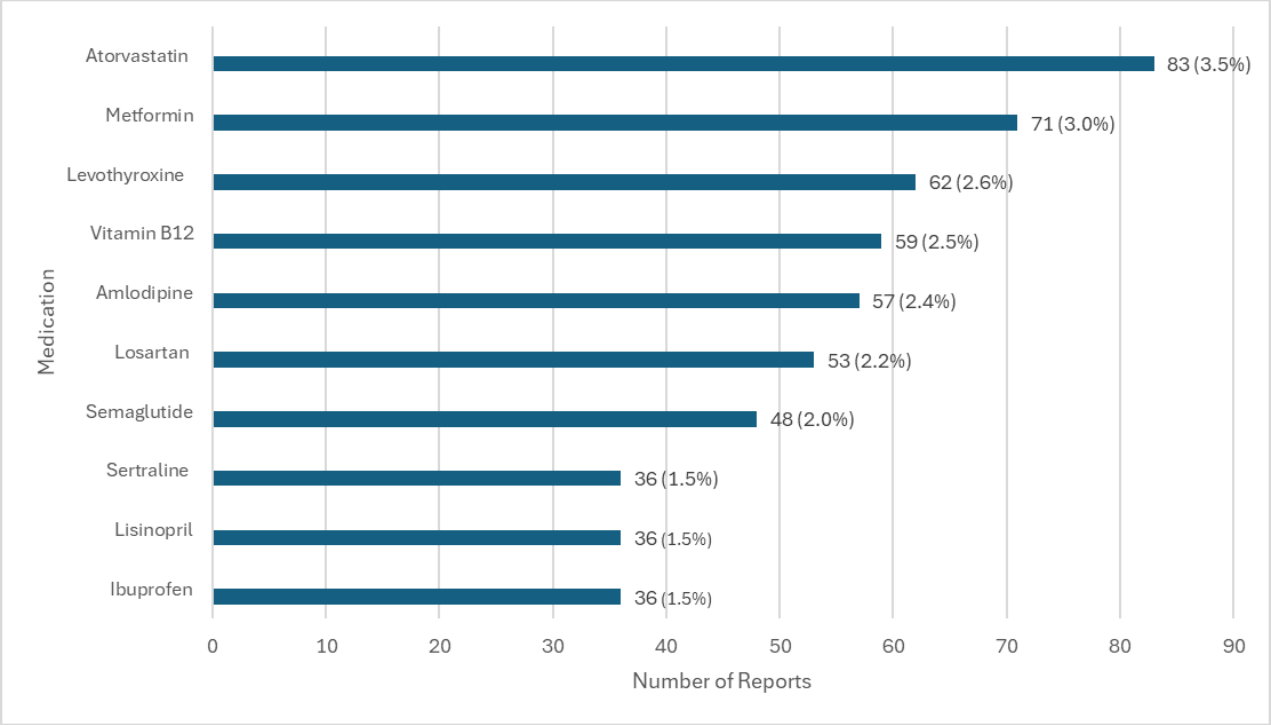

Figure 10. Most common medications involved in wrong patient error, July – December 2025 (N = 2,357).

Similarly, **Figure 11** displays the top five medication classes involved in wrong patient errors. HMG-CoA Reductase Inhibitor, a class of agents used to treat a variety of lipid disorders, was the most commonly (5.9%, n = 139) reported drug class in wrong-patient errors. Glucagon-like peptide-1 (GLP-1) receptor agonists, weight loss and antidiabetic agents which have been demand from patients, was the third (3.7%, n = 88) most reported class of drugs in wrong-patient errors. Opioids, a class of high-alert medications, also appears in the top five classes of drugs involved in wrong-patient errors.

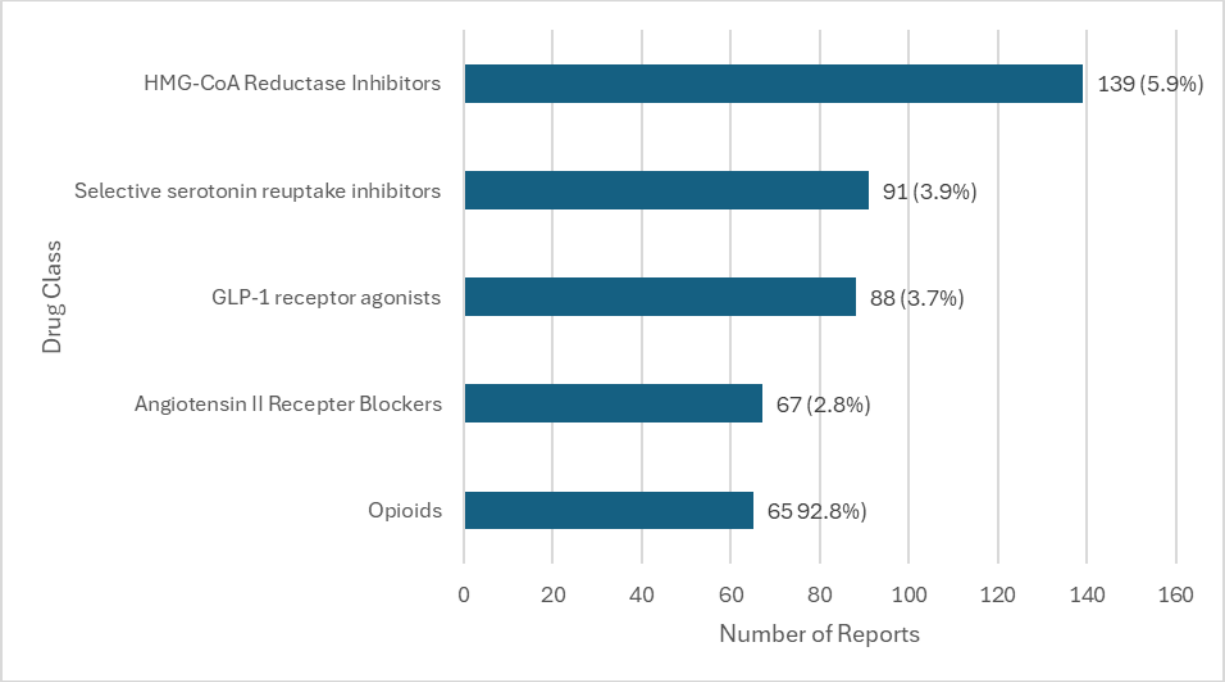

Figure 11. Most common drug classes in wrong patient error, July – December 2025 (N = 2,357).

CAMER Registration Information

Twice a month, the Board provides ISMP with updated data files for active, inactive, and cancelled pharmacy licenses. ISMP populates the CAMER systems with this information to enable registration and to track registration. Based on the information provided by the Board, there are 6,712 pharmacies that are "active." Of these, 5,361 (79.9%) pharmacies have registered for the CAMER system while 1,351 (20.1%) pharmacies have not yet registered. One potential issue may be a time lag between when a pharmacy closes and the pharmacy license is finally cancelled. For example, a pharmacy listed as active in the CAMER system may no longer be open, but cancelled pharmacy licensed data may not yet reflect that closure, falsely elevating the number of pharmacies that have not yet registered.

Appendix A – NCCMERP Harm Score Definitions

Definitions of the NCCMERP harm scores (Source: National Coordinating Council on Reporting and Prevention; Categorizing Medication Errors):

A. Circumstances or events that have the capacity to cause error
B. An error occurred but the error did not reach the patient
C. An error occurred that reached the patient but did not cause patient harm
D. An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm
E. An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
F. An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
G. An error occurred that may have contributed to or resulted in permanent patient harm
H. An error occurred that required intervention necessary to sustain life
I. An error occurred that may have contributed to or resulted in the patient's death

Attachment 3

Jenny Chang
23 Corporate Plaza, Suite 215
Newport Beach, CA 92660

January 5, 2026

Via electronic mail to: Debbie.Damoth@dca.ca.gov

Debbie Damoth
Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

RE: Withdrawal of Petition to Amend 16 CCR § (Regulation) 1709.1

Dear Ms. Damoth:

I withdraw my petition under Government Code section 11340.6 to amend Regulation 1709.1, Designation of Pharmacist-in-Charge, which is set for public hearing on January 6, 2026.

Thank you for your assistance with this matter.

Sincerely,

Jenny Chang

Jenny Chang

cc (via e-email): Office of Administrative Law (staff@oal.ca.gov)
Department of Consumer Affairs (dca@dca.ca.gov)
PharmacyRulemaking@dca.ca.gov