California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business and Consumer Services Agency
Department of Consumer Affairs
Gavin Newsom, Governor

To: **Board Members**

Subject: **Review and Consideration of California Medication Error Reporting (CAMER) Program Annual Report July 2025 – June 2026**

Relevant Law: 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.

Background: 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 previously reported in April 2025, staff have been working with ISMP on implementation activities. That month, 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.

For Member Discussion and Consideration
Consistent with the contract, the Board received the first annual report from ISMP providing summary information of medication error reports submitted to the CAMER system through June 30, 2026.

The report notes that between July 2025 and June 30, 2026, a total of 27,161 medication error reports were submitted to the CAMER system. Reports were submitted by a total of 3,420 pharmacies. The below breakdown summarizes reports submitted by pharmacy type:

- 16,616: community chain pharmacies
- 4,133: non-chain community pharmacies
- 4,060: mail order pharmacies
- 1,396: closed-door pharmacies
- 642: specialty pharmacies
- 314: hospital outpatient pharmacies

Information included in the report (Table 3) reveals that 94.3% of the medication errors report no harm, 5.4% report mild harm, 0.2% report moderate harm, 0.03% report severe harm, and 0.04% report patient death.[1]

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

- Wrong patient (5,873 reports) 21.6%
- Wong quantity (5,668 reports) 20.9%
- Wrong drug (4,621 reports) 17%
- Wrong directions (4,340 reports) 16%
- Wrong strength (2,179 reports) 8%

For wrong patient errors, which were the most commonly reported type of error, the top five most common contributing factors[2] (Table 7) included:

- Human factors (3,457 reports) 58.9%
- Procedure or policy noncompliance (2,379 reports) 40.5%
- Workflow (730 reports) 12.4%
- Training (637 reports) 10.8%
- Environment/space (469 reports) 8%

ISMP noted that analysis of the errors submitted to both the CAMER program and ISMP's National Medication Errors Reporting Program (ISMP MERP) reveals a number of additional ways wrong patient errors occurred, including:

- Working on more than one patient's prescription at a time
- Patients with similar or the same names
- Flawed patient identified processes throughout the dispensing process
- Staff believing they know the patient by sight
- Not reviewing the medication with the patient
- Distractions

The report includes a number of recommendations for pharmacies, including recommendations to help reduce the risk of wrong patient errors, recommendations to thoroughly test and routinely monitor dispensing system functions to reduce the risk of wrong directions errors, and risk mitigation strategies to reduce the risk of frequency errors with methotrexate.

The report also includes recommendations for the Board. Recommendations include:

- A recommendation that Board inspectors ask pharmacies about their patient identification processes and, when on site, observe how these processes are performed.
- A recommendation that the Board require pharmacies to thoroughly test new technology or prescription processing automation before implementation.
- A recommendation that the Board mandate the provision of patient education for methotrexate and other select high-alert medications.[3]

[1] The report further noted that when reading the event narratives of the reports that were categorized as resulting in death, however, eleven of the reports did not describe patient deaths and while one narrative mentioned the death of a canine,it indicated that it was unknown if the error is what caused the pet's death.

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

[3] The report notes that licensees submitted 66 reports involving methotrexate.

Staff note that the draft strategic plan establishes two strategic objectives related to the CAMER program. As part of its discussion, it may be appropriate to include are part of its discussion the Board may wish to address the recommendations offered by ISMP to determine if it is appropriate to refer some of the recommendations to the identified strategic committees for further consideration.

Attachment 1 includes the first annual report from ISMP documenting information learned through reporting of medication errors to the CAMER system.