Standards

IC, patient care plans and medication management are among top challenges

Infection control of medical devices, keeping patient care plans updated, safely storing medications and the perennial problem of timing and dating of medical records dominated the top challenges among clinical standards presented at this year’s Executive Briefing by The Joint Commission (TJC).

At the Sept. 24 session just outside Chicago, the second of three briefings held for hospital executives across the nation, TJC leaders took a new look at how they presented the top (see Executive Briefing, p. 4)

NPSG

Data tracking, staff input are keys to improving clinical alarm management

Conduct staff surveys and track when and why clinical alarms sound to collect the data you need to identify the non-actionable alarms sounding in your hospital and reduce the potential harm they may bring to your patients.

Management of clinical alarm systems is the newest of The Joint Commission's (TJC) National Patient Safety Goals (NPSGs) and one that is receiving a lot of scrutiny thanks to a current lack of established best practices and guidance. (see Clinical alarms, p. 6)

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Executive Briefing: Challenges in EC, LS compliance remain the same

The order on the list changes, but the top most challenging Environment of Care and Life Safety standards for this year are basically the same as those announced last year at the annual Executive Briefing by The Joint Commission (TJC). And the year before. And the year before that, and — well, you get the idea.

Here’s a rundown of the top three, as outlined by George Mills, TJC’s director of engineering and one of the commission officials briefing hospital executives on Sept. 24 just outside of Chicago. (For a look at the top clinical standard challenges, see p. 1.)

- **EC.02.06.01:** This standard, requiring hospitals to set and maintain a “safe, functional environment,” tripped up almost 59% of hospitals surveyed in the first half of 2015, according to Mills’ presentation. Compliance consultants have told *Inside the Joint Commission* that this is a standard where surveyors choose to park unsafe conditions they find when no other standard specifically fits. Mills appeared to agree, warning hospital executives, “I will tell you this is a wild card.”

Problems often arise with **EP 1**, which requires hospitals to meet the needs of the patient population and provide safe and suitable care. It’s this EP that surveyors cite when they find unsecured oxygen cylinders or improper segregation of empty and full cylinders, exposed plumbing, ripped carpet and other unsafe conditions, Mills said.

A cylinder of compressed oxygen that is left lying on an empty gurney or propped against a wall is a potential missile waiting to happen, Mills warned. With regard to the comingling of full and empty containers, Mills reiterated that all the commission requires is full containers be stored in a clearly marked area separate from other containers, including those that are empty or partially used.

As far as surveyors are concerned, he said, there are no partial cylinders — just full cylinders and all others. If hospitals want to mark an area for partial cylinders, that is up to the organization. But the goal is to not make anyone try to guess which cylinder to use in an emergency, he noted. “It should be obvious. This one’s full and then there is everything else,” he said.

EP 1 is also often cited related to conditions that might contribute to a patient attempting to harm himself, said Mills.

Other problems are cited under **EP 13**, which requires hospitals to maintain ventilation, temperature and humidity levels at suitable patient levels. Here surveyors are citing concerns with doors held open by air pressure or because of odors (ventilation); patients with too many blankets (temperature); and condensation on windows, a sign of a humidity control problem that could contribute to mold growth.

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**Standards**

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**Executive Briefing: Challenges in EC, LS compliance remain the same**

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Other odors may be cited under EP 20, which requires that patient care areas be kept clean and free of offensive odors.

- **EC.02.05.01:** Infection control is the main driver behind deficiencies cited under this standard, which requires hospitals to manage risks associated with its utility systems, Mills noted. As one of their primary survey responsibilities, surveyors will be specifically checking to ensure hospitals provide appropriate pressure relationships, air-exchange rates and filtration efficiencies as required under EP 15. The LS surveyor will start by conducting tests in a hospital’s operating rooms immediately after the initial document review, Mills said. That will allow hospitals the most amount of time before the end of the survey to correct any deficiencies found by the surveyor. While condition-level deficiencies may still be noted in the final report, efforts by the hospital to fix the problems could significantly reduce what the hospital would have to do post-survey to show compliance. But the hospital would have to show, among other things, that the resolution ensured air-pressure balance in the whole area, not just the location where the deficiency was identified, and that the hospital had an ongoing process to assess compliance in the future, Mills said.

- **LS.02.01.20:** Almost half of hospitals surveyed faced challenges with maintaining the means of egress. Sometimes that challenge was under EP 1, which requires doors to be free of latches or locks that require a tool or key to be opened — unless locked for patient security, in which case a staff member must be readily available to open the door. Other times the challenge is the dreaded “corridor clutter.”

Mills reminded hospital executives that anything in an egress corridor for more than 30 minutes is considered storage, unless it is in use. Exceptions are crash carts, isolation carts and chemo carts, which are considered always in use or may be needed quickly in an emergency. If staff seems reluctant to deal with corridor clutter because it poses more work, Mills recommended putting it in terms staffers could relate to — the clutter poses a potential danger to their own safety if they are injured as they try to maneuver around something. (For a full outline of EOC challenges, see IJC’s *sibling publication* Environment of Care Leader.) — A.J. Plunkett (aplunkett@decisionhealth.com)

**NPSG**

**Follow these 5 steps to help make your clinical alarm processes safer**

Data collection, review and iteration are necessary to improve the safety of your clinical alarm systems. Maria Cvach, RN, assistant director of nursing and clinical standards at Johns Hopkins Hospital in Baltimore, and Dr. Roland Wyatt, MHA, medical director in the Division of Healthcare Improvement for The Joint Commission, offered this advice during a recent webinar sponsored by the Association for the Advancement of Medical Instrumentation Foundation (For more from the webinar, see p. 1):

- **Take advantage of technology, but don’t assume it will solve every problem.** Technology is great for alerting staff about alarms, but you must analyze what alarms are most appropriate for attachment to technological devices such as phones, says Cvach. Attaching low-risk or non-actionable alarms to such systems will only distract from more important alarms. Use an escalation process for deciding how and when to send alerts through such a device, she says.

- **Gather the baseline alarm data throughout the hospital.** “The data we saw in the [cardiovascular surgical intensive care unit] was different from what we saw in pediatric,” notes Cvach. This means that any interventions you propose for one unit are unlikely to work in the same way in other areas of the hospital.

- **Go small on parameter changes.** Small, subtle tweaks to existing alarm parameters can go a long way. As Cvach’s team at JHH found out, often all you need is to eliminate certain problematic alarms. She adds that sweeping changes will often leave your team disappointed and frustrated, as such changes can often cause additional alarm issues in place of the ones they are meant to remove. “Small, targeted changes are much more successful,” she observes.

- **Sustain educational efforts.** Evolving best practices and the varied nature of alarm systems based on unit and patient needs means that any education you provide to staff on alarm systems will have to be continually updated and emphasized with staff on a regular basis, says Wyatt. Leadership support and forming a multidisciplinary alarm management committee can help press the importance of clinical
alarm management practices to staff, while also reviewing and assessing adherence to said practices.

- **Take advantage of available resources.**

There are a number of resources available for hospitals to use as a guide for reviewing their existing alarm management policies. The Association for the Advancement of Medical Instrumentation Foundation (AAMI) has several resources available on its website, and both AAMI and TJC have offered seminars covering the topic that help illustrate improvement techniques. — **Steven Dashiell** (sdashiell@decisionhealth.com)

**Resource:**


**Medical devices**

### FDA adds Patient Engagement Advisory Committee to improve medical devices

Keep an eye on the FDA's new advisory committee and reach out to your patient population and incorporate their feedback into your care practices, including how you select and use medical devices.

The FDA recently added patient engagement to its collection of advisory committees dedicated to the improvement of various aspects of public health and the health care industry. This brings its advisory committees up to 12 total, including topics such as Drugs, Medical Devices, Radiation-Emitting Products and Blood, Vaccines and Other Biologics.

Despite the broad name, the Patient Engagement Advisory Committee looks to provide advice to the FDA on “complex issues relating to medical devices, regulation of devices, and their use by patients,” according to the FDA's official site. Unlike the Medical Device Advisory Committee, which gathers the input of experts within the medical device manufacturing field as well as those who use them, the Patient Engagement Advisory Committee includes individuals with knowledge and experience in areas such as clinical research, primary care patient experience and the health care needs of patient populations within the United States.

The results of this committee could bring significant changes to how medical devices are developed and assigned to patients, says Jen Cowel, a former Joint Commission surveyor and vice president at Patton Healthcare Consulting.

“The charter for the committee indicates they will be focused on patient perspective, new approaches and innovation. I could see a patient engagement advisory committee as providing valuable insight as the FDA approaches innovative personal health devices that are being made possible by apps and wearable technology,” she observes.

Existing controversy over medical devices and whether they need FDA approval, such as personal devices that monitor health information such as EKG, heart rate or blood glucose, creates a good argument for the value of this committee, says Cowel. “How the FDA approaches innovative technologies in a broad sense could be well served by a committee of patients and other consumers.”

The committee’s creation is a timely one, as more hospitals are exploring the use of tablets, smartphones and apps during patient care and device makers become more interested in catering to the health care industry’s needs.

“I do think the landscape is changing quickly and there is no downside to soliciting advice,” says Cowel.

For more on the Patient Engagement Advisory Committee and how to submit a nomination, go to [http://tinyurl.com/FDA-patient-advisory](http://tinyurl.com/FDA-patient-advisory). Nominations will be accepted through Oct. 21. — **Steven Dashiell** (sdashiell@decisionhealth.com)

**Executive Briefing**

*(continued from p. 1)*

challenges, even as they encouraged hospitals to take a new look at why the same standards pose the same problems year after year.

A chief attraction of the annual briefing is the examination of the top challenges facing hospitals surveyed in the first half of the year. This year, the challenges in clinical standards were separated out from those in the environment of care, which always dominate the list. *(What’s behind the top 3 most challenging EOC standards? See p. 2.)*

**IC, timing and dating still top list**

In reviewing the most challenging of the clinical standards, Doreen Finn, RN, BSN, MBA, TJC’s senior associate director of the Division of Healthcare...
Improvement, Standards Interpretation Group, drew comments and survey observations from actual reports on the hospitals surveyed.

She urged the executives to take the sample observations back to their own hospitals to look for similar deficiencies. “These should be hints for you to … do some investigation to show where you are,” Finn advised.

Topping the list were standards that regularly make the top 10 — Infection Control (IC) and Record of Care, Treatment and Services (RC). Here are highlights of those and other challenges presented by Finn:

- **IC.02.02.01:** More than half the hospitals surveyed were scored by surveyors under this standard, which calls for reducing the risk of infection related to medical equipment, supplies and devices.

  While competency and training of personnel who perform sterilization and high-level disinfection (HLD) of devices remains one of the biggest problems under the standard, surveyors were also seeing a failure to update or even follow the hospital’s existing policy on infection control, said Finn.

  “Remember if you put something into writing, The Joint Commission will be looking to see if you follow what you have prescribed as the right procedure,” Finn warned.

  While competency and training of personnel was a problem, so too was staff supervision. Too often whoever was supervising the personnel performing sterilization and HLD didn’t have the knowledge needed to do the job, Finn observed.

  Evidence-based guidelines are not being followed, and some organizations are struggling to even know what guidelines to follow or where to find them, she said.

  Those guidelines as well as the manufacturers’ instructions for use on everything from equipment and devices to the biological indicators used in the sterilization and HLD must be made available to staff, Finn stressed.

  Sample observations included a lack of documentation to show competency and training for central sterile technicians, no process to ensure that tools and brushes used to decontaminate equipment and devices were cleaned afterward, repeated use of “single-use” brushes, and no evidence that an organization was documenting lot numbers of the biologicals and their controls.

- **RC.01.01.01:** Once at the top of the list, this Record of Care standard is slowly falling in frequency, with just less than half the hospitals surveyed found deficient for problems in maintaining complete and accurate medical records for each individual patient. TJC expects fewer deficiencies in the future as the use of electronic health records continues to grow and improve.

  For now, however, the most problematic elements of performance (EPs) still are in the timing and dating of entries, as well as legibility of handwritten records. The improper use of signature stamps as well as medical staff buy-in on complying with the standard remain the top issues behind the RFIs, Finn noted.

- **PC.01.03.01:** Under this Provision of Care standard, hospitals are required to plan a patient’s care. But Finn noted many hospitals struggle with **EP 1**, which calls for patient care plans based on needs identified during initial patient assessment, reassessment and following test results; **EP 5**, which requires written plans based on patient goals that include a timeframe for meeting those goals; **EP 22**, which requires staff evaluation of patient progress toward meeting those goals; and **EP 23**, which calls for goals to be revised based on patient needs.

  Examples taken from surveys included instances of a plan of care that did not reflect the assessed needs of a post-surgical patient, another plan of care that did not show any evidence of discharge planning and another in which no revisions were made to a care plan to treat a new diagnosis of diabetes.

  Time frames for reaching goals were particularly challenging. “It’s not appropriate to have ‘by discharge’ for every single patient,” Finn admonished hospital leaders.

- **MM.03.01.01:** Two Medication Management standards proved so challenging, that not only were hospitals scored on them, but they were also on the top 10 list of standards hospitals most often asked TJC to clarify. MM.03.01.01, requiring hospitals to safely store medications, was top on the list of inquiries to the Standards Interpretation Group, according to Finn’s presentation.

  Half of the 12 EPs under the standard are problematic for hospitals, including:

  - **EP 7**, on storing medications and their components with labels that include the expiration date and applicable warnings.

  - **EP 2**, requiring medications to be stored according to manufacturer’s recommendations.
- **EP 3**, requiring drugs and biologicals to be stored in secure areas to prevent diversion.
- **EP 6**, calling for the hospital to prevent unauthorized individuals from obtaining drugs.
- **EP 8**, requiring the removal or separate storage of expired, damaged or contaminated drugs.
- **EP 10**, which requires drugs to be available in patient care areas in a readily administered form or, if feasible, repackaged by the hospital pharmacy.

Under these EPs, hospitals were scored for not being able to show evidence of monitoring refrigerator temperatures where vaccines were stored, IV fluids in a fluid warmer that were not monitored according to manufacturer's recommendations, unlocked anesthesia carts in an operating area, and a controlled substance that was not securely stored.

While certain staff may have access to a patient care area, some workers still should not have access to medications, Finn noted. As for vaccines, Finn recommended hospitals check the CDC's website on the proper storage of vaccines. *(Find CDC information on vaccines at [http://www.cdc.gov/vaccines/recs/default.htm#storage](http://www.cdc.gov/vaccines/recs/default.htm#storage).)*

- **IC.02.01.01**: This is another IC standard that has drawn attention of late. IC.02.01.01 requires hospitals to implement its infection prevention and control plan, which Finn noted, under EP 1, must include surveillance to eliminate, reduce or minimize infection risk. What did surveyors see as they walked through patient care areas? Chairs in a patient's room with cracked plastic and leather that had been repaired with strips of tape that are then hard to fully clean; a swimming pool in a physical therapy department with chemicals out of acceptable range; and dirty ice machines.

In one case Finn characterized as now “infamous,” one hospital's cafeteria ice machine was found with dirt and mold clearly around the dispenser and catch tray.

- **MM.04.01.01**: This standard requires simply that “medication orders are clear and accurate.” But with 14 EPs and multiple notes, the standard is the second of the two under Medication Management that sends hospitals to seek clarification with the Standards Interpretation Group, according to Finn's presentation.

The problems surveyors find are most often under EP 13, which calls for a hospital to implement its own policies on medication orders, and **EP 6**, which says to minimize the use of verbal or phoned-in medication orders.

Examples of problems included orders for medication “as needed” without a specific indication outlined as required under the hospital's own policy, therapeutic duplication problems when two medications are written for the same indication without orders on when to give each, and inaccurate or incomplete medication orders in a patient’s chart — against the hospital's own policy.

Duplication of drug orders “leaves our nurses in a very difficult situation,” Finn observed, adding that there might also be scope-of-practice issues when nurses are left to decipher an order's intent.

“Go back to your policy to see what you want your staff to be doing,” Finn advised. “We need to have clear-cut guidelines for our nursing staff when they are carrying out medication orders.” *(For five more challenging clinical standards, see the next Inside the Joint Commission.)* — A.J. Plunkett (aplunkett@decisionhealth.com)

**Clinical alarms**

*(continued from p. 1)*

Announced in 2014, **NPSG.06.01.01** first required hospitals to establish clinical alarm safety as a priority and identify the alarms most important to patients. The final expectations set out in **EP 3** and **EP 4** must be fully implemented by Jan. 1, 2016.

These elements of performance require facilities to have established policies and procedures for managing those critical alarms and to educate staff and licensed independent practitioners about the purpose and proper operation of the alarm systems for which they are responsible, noted Dr. Ronald Wyatt, MHA, medical director in the Division of Healthcare Improvement at TJC.

Wyatt was part of a recent webinar panel sponsored by the Association for the Advancement of Medical Instrumentation Foundation (AAMI).

‘Are You Ready?’

The webinar, “Alarm Safety Update: Are You Ready?” took a look at the challenges clinical alarms can present and how poor management of these alarms can lead to serious consequences for patients.
Wyatt recounted the case of a 62-year-old patient who had been admitted to a hospital ICU. After multiple low-risk alarms for the patient sounded, a nurse suggested turning the alarms off. At some point shortly thereafter, the red apnea alarm was turned off. Later, a nurse entering a different patient room commented that the 62-year-old patient “looks dead.” When no pulse was found, the physician questioned why no alarms were sounding. The patient was declared dead.

“Out of the 10,000 alarms that occur every day, 85 to 99 percent of them don’t require clinical intervention,” noted Wyatt. The sheer number of these daily alerts can result in alarm fatigue, in which many alarms go unheard by staff altogether or, as demonstrated in the case of the 62-year-old patient, intentionally disabled.

The occurrence of clinical alarm-related issues in facilities is trending upwards, and surveyors are going to be looking at these EPs moving forward, said Wyatt.

Johns Hopkins cuts clinical alarms

Johns Hopkins Hospital (JHH) in Baltimore is among facilities who have been working for years to reduce clinical alarm-related errors and JHH experts explained their improvement process during the seminar. (Steps for improvement, see p. 3.)

The JHH cardiovascular surgical intensive care unit (CVSICU) is an 18-bed, high-acuity surgical ICU. Patients there, especially those who have undergone bypass and valve surgical procedures, heart and lung transplants or extracorporeal membrane oxygenation, experience rapid changes in vital signs, says Maria Cvach, RN, assistant director of nursing and clinical standards at JHH.

Most of the patient rooms are private and the nursing stations in the CVSICU are far apart. This means nurses were loaded down with wireless phones and pagers in order to receive notice of the alarms going on throughout the ICU, said Cvach.

With data indicating nearly 208 alarms sounding per bed per day and an average of 14 beds reporting data daily, the number of alarms received by the nurses was extremely high — yet only 1% of those were high priority, explained Cvach. “We sought to reduce the amount [of alarms] they had to worry about.”

JHH began by testing the nurses with audio snippets of the alarms the hospital used for various conditions to determine whether they could identify the alarm based on sound alone. Only two alarms were identifiable with 100% accuracy, and many alarms scored in the below-40% category.

A follow-up survey was conducted to understand what nurses felt were the largest “nuisance alarms” — those that often required the least attention.

Many of these nuisance alarms, such as arterial line SDM, SPO2 low, and SPO2 probe, were those that fell into the lower category of recognized alarm sounds.

Improvement rollout

With data in hand, JHH created a plan that would meet four goals for improving their clinical alarm systems: decrease the quantity of alarms, decrease
the time to alarm response, increase audible alarm recognition and improve overall staff attitudes about alarms.

JHH rolled this plan out in stages, said Sharon H. Allan, CVSICU clinical nurse specialist at the hospital. Phase I involved the paring down of many of the extraneous alarms that were deemed “nuisances,” such as hallway waveform monitors, and later, a number of parameter changes to existing alarms.

Phase II, that took place February through March 2015, included auditing how and when nurses could tweak these parameters and customize these alarms. “Any bed that had greater alarms than the mean was noted,” explained Allan. “We would go to that bed and evaluate why and what alarms were going off.”

During this review, the evaluation team noted that a number of these alarms were signaling unnecessarily from the perspective of the patient’s unique condition. Rather that excise these alarms, often it was a matter of tweaking the parameters of when these alarms would sound, noted Allan.

The final phases of the project, which coincided with the aim of improving overall staff attitude about alarms, involved the elimination of pagers for alarms and moving everything over to a phone-based system.

This wasn’t possible to do from the start of the project because of the sheer number of alarms the hospital still had to deal with. Moving every alarm a staff member receives over to the phone would have been “possibly overwhelming,” and slimming those alarms down to only the most important and actionable was important for improving the experience, explained Allan.

Though the project is still young, some early data has proven positive for JHH, with daily alarm occurrence continuing to average lower since implementation and staff attitude toward alarms improving, particularly when the pager was removed as an alarm source, says Allan.

—Steven Dashiell (sdashiell@decisionhealth.com)

Resources:

- The Joint Commission Sentinel Event Alert 50: http://www.jointcommission.org/assets/1/18/SEA_50_alarms_4_5_13_FINAL1.PDF

Life safety

What’s wrong with this picture? Remind staff of holiday decorations policy

Halloween is just around the corner, with Thanksgiving and Christmas holiday seasons close behind. Now’s the time to break out your holiday decoration policy and remind staff of the do’s and don’ts. And just for fun, see if you can identify what’s wrong with these pictures, provided courtesy of Ernie Allen, ARM, CSP, CPHRM, CSHP, a compliance consultant with The Doctor’s Company, based in Ohio, during a presentation at the 2015 EC Summit, sponsored last month by Inside the Joint Commission publisher DecisionHealth in Las Vegas. Send your answers to aplunkett@decisionhealth.com and we’ll publish a few in the next IJC. —A.J. Plunkett (aplunkett@decisionhealth.com)
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