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Clearly and concisely provides guidelines for appropriate and careful documentation of care. Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. In addition, it plays a large role in how third party payors make payment or denial decisions. This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment. Special attention focuses on the latest documentation issues specific to specialty settings, such as acute care, home care, and long-term care, and a variety of clinical specialties, such as obstetrics, pediatrics, and critical care.--Amazon.com.

Please note that this eBook does not include the DVD accompaniment. If you would like to have access to the DVD content, please purchase the print copy of this title. Now in its 3rd edition, Potter & Perry's Fundamentals of Nursing continues to be the definitive text for nursing students in our region. The new edition builds on the strengths of the highly successful previous editions with greater authorship, increased local research, evidence and concepts particular to the health care systems of Australia and New Zealand. Fully revised and updated by leading Australian and New Zealand nurse educators. It presents essential nursing skills in a clear format consistent with Australian and New Zealand practice, placing greater emphasis on critical thinking skill explanations, revised procedural recommendations, infection control considerations and updated medications information. Health Care Delivery System (Chapter 2) – now includes New Zealand content and walks the student through the evolution of health care delivery systems in our region. Engaging in Clinical Inquiry and Practice Development (Chapter 5) written by Jackie Crisp and Professor Brendan McCormack provides a contemporary perspective on the processes underpinning nursing knowledge development, utilisation and their role in the ongoing advancement of nursing practice. Managing Client Care (Chapter 20) is an exciting newly revised chapter that engages the student in exploring nursing issues in managing client care within the context of contemporary health care systems. New Chapter on Caring for the Cancer Survivor New Zealand Supplement Legal Implications of Nursing Practice Now includes evolve e-books Now students can search across Potter & Perry’s Fundamentals of Nursing 3E electronically via a fully searchable online version. Students can take notes, highlight material and more. The e-book is included with this edition at no extra cost. New Resources for Students and Instructors on Evolve: Nursing Skills Online for Fundamentals of Nursing provides students with 17 interactive modules which expand on textbook concepts, through the use of media rich animations. It encourages decision-making and critical-thinking skills through case-based and problem-oriented lessons. Nursing Skills Online for Fundamentals of Nursing may be purchased separately as a User guide & Access code (ISBN: 9780729539388) Online Study guide for students is an ideal supplement with Skills Performance Check lists designed to challenge students’ abilities. Clinical knowledge can be further tested through additional short answer and review questions.

The Fifth Edition of Nursing Care Plans and Documentation provides nurses with a comprehensive guide to creating care plans and effectively documenting care. This user-friendly resource presents the most likely diagnoses and collaborative problems with step-by-step guidance on nursing action, and rationales for interventions. New chapters cover moral distress in nursing, improving hospitalized patient outcomes, and nursing diagnosis risk for compromised human dignity. The book includes over 70 care plans that translate theory into clinical practice.Online Tutoring powered by Smarthinking--Free online tutoring, powered by Smarthinking, gives students access to expert nursing and allied health science educators whose mission, like yours, is to achieve success. Students can access live tutoring support, critiques of written work, and other valuable tools.

Build the nursing knowledge and skills you need to care for patients of all ages! Combining two leading LPN/LVN textbooks into one volume, Foundations and Adult Health Nursing, 9th Edition covers the fundamental skills and medical-surgical content essential to providing quality care for patients across the lifespan, including pediatric, maternity, adult, and older adult patients. Case studies provide practice with critical thinking and clinical judgment, and new Next Generation NCLEX®-format questions help you apply theory to practice. Written by nursing educators Kim Cooper and Kelly Gosnell, this text also helps you prepare for success on the NCLEX-PN® examination.

Nursing can be nuts. On a twelve-hour shift, the last thing most nurses want to do is sit down and draft a lengthy note describing the craziness that occurred. Written by a nurse, for nurses, this book is chock full of narrative note examples describing hypothetical situations to help you describe the, well, the indescribable. Some shifts are just like that!

Make sure you have the foundation you need to begin a successful nursing career! Foundations of Nursing, 8th Edition covers the skills needed for clinical practice, from nursing interventions to maternity, neonatal, pediatric, geriatric, mental health, and community health care. Guidelines for patient care are presented within the framework of the nursing process; Nursing Care Plans are described within a case-study format to help you develop skills in clinical decision-making. The accessible, friendly overall style and clearly written review questions also helps you prepare for the NCLEX-PN® examination! Clear coverage of skills across the human lifespan includes maternity, pediatrics, adults, and older adults. Full-color, step-by-step instructions for over 110 skills show nursing techniques and procedures along with rationales for each. Tenth grade reading level helps you to understand complex topics. Expanded and updated Cultural Considerations boxes explore specific health and cultural issues to help you address the needs of the increasingly diverse patient and resident populations. Skills are presented in a step-by-step format with clearly defined nursing actions and rationales. Mathematics review in Dosage Calculation and Medication Administration chapter covers basic arithmetic skills prior to the discussion of medication administration. Safety Alerts cover issues related to safe patient care in a variety of settings. Health Promotion Considerations boxes highlight information on wellness and disease prevention, including infection control, diet, and pregnancy. Nursing Care Plans emphasize patient goals and outcomes within a case-study format, and promotes clinical decision-making with critical thinking questions at the end of each care plan. Patient Teaching boxes include post-hospital discharge guidelines and disease prevention instructions with a strong focus on three-way communication among the nurse, patient, and family members. Communication boxes illustrate communication strategies using real-life examples of nurse-patient dialogue. Lifespan Consideration boxes provide you with age-specific information for the care of the patient. Home Health Considerations boxes discuss issues facing patients and their caregivers in the home setting. Get Ready for the NCLEX® Examination section at the end of each chapter provides Key Points, Review Questions, and Critical Thinking Activities to reinforce learning. Coordinated Care boxes promote comprehensive patient care with other members of the health care team, focusing on prioritization, assignment, supervision, collaboration, delegation, and leadership topics.

Written by a multidisciplinary panel of experts, this comprehensive text and reference presents a fundamental understanding of all aspects of parish nursing, providing in-depth information essential to understanding the ministry of a parish nursing practice. This is the only text in parish nursing that addresses the role of the parish nurse administrator, and includes suggested policies and procedures as well as recommendations for competency development for parish nurses.

A vital member of the health care team, the contemporary enrolled nurse faces increasing challenges and an increasing level of responsibility. Written specifically for Australian and New Zealand enrolled nurse students, this long awaited new edition reflects the changes and challenges in contemporary enrolled nurse practice as well as the additions and modifications that are occurring in nursing curricula. Tabbner’s Nursing Care: Theory and Practice 5th edition has been written, reviewed and edited by the people who educate the enrolled nurse and continues to provide enrolled nurse students with the most comprehensive resource available.

Pamphlet is a succinct statement of the ethical obligations and duties of individuals who enter the nursing profession, the profession's nonnegotiable ethical standard, and an expression of nursing's own understanding of its commitment to society. Provides a framework for nurses to use in ethical analysis and decision-making.

Armed with this portable handbook, nurses in any practice setting will know exactly what to document in any situation. Featuring an A-to-Z organization that makes finding information easy, this reference offers a new learn-by-example approach to charting and delivers clear examples for documenting more than 270 patient-care situations, from common diseases to legal and ethical issues. "Legal casebook" spotlights real-life court cases to help you avoid perilous charting. Completed "AccuChart" sample forms--such as OASIS, incident reports, and fall prevention reports--give readers the confidence to chart accurately at all times.

Health spending continues to grow faster than the economy in most OECD countries. In 2010, the OECD published a study of strategies to increase value for money in health care, in which pay for performance (P4P) was identified as an innovative tool to improve health system efficiency in several OECD countries. However, evidence that P4P increases value for money, boosts quality of processes in health care, or improves health outcomes is limited.This book explores the many questions surrounding P4P such as whether the potential power of P4P has been over-sold, or whether the disappointing results to date are more likely rooted in problems of design and implementation or inadequate monitoring and evaluation. The book also examines the supporting systems and process, in addition to incentives, that are necessary for P4P to improve provider performance and to drive and sustain improvement. The book utilises a substantial set of case studies from 12 OECD countries to shed light on P4P programs in practice.Featuring both high and middle income countries, cases from primary and acute care settings, and a range of both national and pilot programmes, each case study features: Analysis of the design and implementationdecisions, including the role of stakeholders Critical assessment of objectives versus results Examination of the of 'net' impacts, includingpositive spillover effects and unintended consequences The detailed analysis of these 12 case studies together with the rest of this critical text highlight the realities of P4P programs and their potential impact on the performance of health systems in a diversity of settings. As a result, this book provides critical insights into the experience to date with P4P and how this tool may be better leveraged to improve health system performance and accountability. This title is in the European Observatory on Health Systems and Policies Series.

Designed for rapid on-the-job reference, Documentation in Action offers comprehensive, authoritative, practice-oriented, up-to-the-minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties. Need-to-know information is presented in bulleted lists, charts, flow sheets, sidebars, and boxes, with icons and illustrative filled-in samples. Coverage includes documentation for care of patients with various diseases, complications, emergencies, complex procedures, and difficulties involving patients, families, and other health care professionals. Suggestions are given for avoiding legal pitfalls involving telephone orders, medication reactions, patients who refuse care, and much more. A section addresses computerized documentation, HIPAA confidentiality rules, use of PDAs, nursing informatics, and electronic innovations that will soon be universal.

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)." - online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk/

Reinforce your understanding of LPN/LVN nursing skills — and prepare for the NCLEX-PN® exam!

Corresponding to the chapters in Foundations of Nursing, 9th Edition, this study guide provides a variety of exercises to help you review, practice, and apply nursing concepts and principles. Review questions make it easier to achieve the chapter objectives from the textbook, and critical thinking activities help you develop clinical judgment skills. Now with Next Generation NCLEX® (NGN)-style case studies and questions, this guide provides you with an effective study tool for the NGN exam. Variety of exercises reinforces student understanding of nursing fundamentals with multiple-choice, matching, and select-all-that-apply questions, as well as crossword puzzles. Critical thinking activities ask students to apply their knowledge to clinical scenarios. Textbook page references are included for questions and activities, simplifying lookup and review. Answer key is provided on the Evolve website for Foundations of Nursing. NEW! Next Generation NCLEX® (NGN)-style questions provide practice for the new question formats on the NCLEX-PN® exam. NEW! Updated exercises correspond to the new and revised content in Foundations of Nursing, 9th Edition. NEW! Case studies allow students to practice and apply clinical judgment skills.

You can be an excellent nurse in the clinical setting and still fail to prove that you are an excellent nurse if your documentation is inadequate. Having worked in a variety of inpatient and outpatient settings, I understand the obstacles nurses face. There's just not time, nor do nurses have the mental energy to meticulously document every little thing on top of the rest of their to-do list. That's part of why I became passionate about documentation education. It doesn't have to be an overwhelming, endless challenge to chart exhaustively in hopes that you enter enough data into the chart to defend yourself one day. Rather, leveraging the most critical data, knowing how to format notes and exactly what to say, and when to spend five minutes dumping information into the chart can be learned skills that make documentation faster, easier, and less stressful, while doing a better job of defending your actions. The Importance of Documentation & Overcoming Obstacles Purpose(s) of Documentation Defensive Charting Obstacles Impacting Quality of Medical Record Overcoming Obstacles Legal Responsibilities of the Nurse Duties of the Nurse Nurse Practice Acts Duties of the Hospital Hospital Policy vs. State Board of Nursing Regulations Reasonable Prudence Failure to Fulfill (Document) Responsibilities Fulfilling Responsibilities vs. Documenting Responsibilities What if Responsibilities Aren't Fulfilled? Mistakes Happen Professional Liability Insurance Malpractice Medical Negligence Acting with Malice Fraud What Happens When a Nurse is Charged with Malpractice? What to Do if You Receive Notification of a Claim Common Charting Mistakes & How to Avoid Them The Most Common Errors Charting By Exception & Charting to Capture Minimal Data "But I've Always Charted This Way, and Nothing Bad Has Happened Yet..." What You Should Be Charting How and What to Chart Quick Glance Charting Checklists What is a Timely Manner? Documenting Assessments Sample Focused Assessment Criteria Sharing the Responsibility Modifying Electronic Data Abbreviations Standing Orders Early Warning Systems Scores & Scales Informed Consent Special Circumstances Paper Charting Writing an Incident Report Patient Leaving AMA Patient Threatening to Sue You Identifying Patient Belongings Another Member of the Team is Not Documenting Correctly Restraints Defective Equipment Suspected Abuse Patient Requesting to View Their EMR on Hospital Computer Narrative Notes When & How to Write Notes One Note or Several Notes? Daily Narrative Notes Examples of Common Notes Written As-Needed How to Title Narrative Notes How to Format Notes Using Patient Names in Notes Length of Notes Create a Template Tips for Less Stress When Charting BONUS: How I Chart on a "Typical" Shift ABOUT THE AUTHOR: I'm Andrea, RN-MSN. Perfecting my own documentation and working to find concrete guidelines to share with my fellow nurses has become my passion. As I gained more knowledge and researched the dusty, forgotten corners of the internet for obscure evidence-based practice and case studies, becoming a subject matter expert on nursing documentation lit a spark because sharing this information helps empower nurses to understand exactly what should appear in their patient charts, where, when it should entered, and how it should be phrased.

Improving Nursing Documentation and Reducing Risk Patricia A. Duclos-Miller, MSN, RN, NE-BC In the age of electronic health records (EHR) and value-based purchasing, accurate and complete nursing documentation is crucial. Proper documentation affects not only quality of care, but also facilities' costs and revenues. Redundant documentation wastes time and money, while inadequate documentation negatively affects Joint Commission core measures and can result in license suspensions or legal action against a healthcare facility--an expensive and often damaging outcome. Improving Nursing Documentation and Reducing Risk helps nurse managers create policies, processes, and ongoing auditing practices to ensure that complete and accurate documentation is implemented by their staff, without creating additional time burdens. Nurse managers, especially new nurse managers, do not clearly understand their legal accountability for poor or inadequate documentation created by nursing staff who report to them. While each state's nurse practice act (NPA) differs, every NPA addresses nursing liability for documentation; however, many nurse managers remain unaware of these and other regulations that hold them accountable for the documentation crafted by their nurses. This book helps nurse managers protect themselves and their staff by clearly explaining to their employees the impact of documentation practices on reimbursement, educating them on the consequences of failure to document, and training them on how to document properly. This book will help you: Work directly with your staff to ensure accurate documentation Train nurses during orientation Educate your staff on the consequences of inaccurate documentation Create steps to share with your staff that will improve documentation Ensure complete comprehension of documentation issues through sample forms, auditing tools, and case studies Table of Contents Chapter 1: Contemporary Nursing Practice Includes Good Documentation Chapter 2: Contemporary Nursing Standards: Why it's Important for Nurses to Document Well Chapter 3: Reducing Professional Risk Through Documentation Chapter 4: Barriers to Good Nursing Documentation Chapter5: Improving Nursing Documentation Chapter 6: Electronic Medical Records: Advantages and Challenges to Good Nursing Documentation Chapter 7: Ways to Engage and Motivate Staff to Document Well Chapter 8: Improving Documentation and Outcomes

Focuses on the communicatiion skills that are the key to good documentation.

"A Guide for International Nursing Students is an essential resource for overseas nurses and international students of nursing in Australia and New Zealand. It assists the reader to develop essential communication skills for practice as a student and registered nurse in the region. A companion CD allows the reader to become familiar with authentic nursing conversations and nursing handovers."--Provided by publisher.

Charting: An Incredibly Easy! Pocket Guide provides time-starved nurses with essential documentation guidelines in a streamlined, bulleted format, with illustrations, logos, and other Incredibly Easy! features. The book is conveniently pocket sized for quick reference anytime and anywhere. The first section reviews the basics of charting, including types of records, dos and dont's, and current HIPAA and JCAHO regulations. The second section, alphabetically organized, presents hundreds of examples and guidelines for accurately charting everyday occurrences. Logos include Help Desk best practices tips; Form Fitting completed forms that exemplify top-notch documentation; Making a Case documentation-related court cases; and Memory Jogger mnemonics.

Enter the world of nursing care planning with confidence! This informative guide is the perfect way to build your care planning and documentation skills. Practical and easy-to-read material covers each phase of care plan development and record-keeping for both surgical and non-surgical interventions.

Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal comminication in nursing to help you.

This seventh edition includes new chapters and maintains popular features from previous editions such as self awareness prompts while adding research boxes and student worksheets at the end of each chapter.

Now in its Ninth Edition, this full-color text combines theoretical nursing concepts, step-by-step skills and procedures, and clinical applications to form the foundation of the LPN/LVN course of study. This edition features over 100 new photographs, exciting full-color ancillaries, end-of-unit exercises, and extensively updated chapters on nursing foundations, laws and ethics, recording and reporting, nutrition, fluid and chemical balance, safety, asepsis, infection control, and medication administration. Coverage includes new information on cost-related issues, emerging healthcare settings, concept mapping, malpractice, documentation and reporting, HIPAA, and more. All Gerontologic Considerations sections have been thoroughly updated by renowned experts.

Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards, and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards, and documenting outcomes and interventions for key nursing diagnoses.

Focusing on the legal implications in the US, this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice.

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy!®, 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEWdiscussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don’ts of charting – a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient’s health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter’s content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans “Nurse Joy” and “Jake” – expert insights on the nursing process and problem-solving That’s a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina.

Provides information on documentation issues, including electronic medical records, legal and ethical implications, and documentation in acute cases, along with a variety of charting examples.

Chart Smart: the A-to-Z Guide to Better Nursing Documentation tells nurses exactly what to document in virtually every type of situation they may encounter on the job, no matter where they practice--hospital, medical office, outpatient, rehabilitation facility, long-term care facility, or home. This portable handbook has nearly 300 entries that cover documentation required for common diseases, major emergencies, complex procedures, and difficult situations involving patients, families, other health care team members, and supervisors. In addition to patient care, this book also covers documenta

This book presents the outcomes of the 8th International Conference in Methodologies and Intelligent Systems for Technology Enhanced Learning held in Toledo (Spain) hosted by the University of Castilla-La Mancha from 20 th to 22nd June 2018. Further expanding the topics of the previous editions, the conference provided an open forum for discussing intelligent systems for technology enhanced learning (TEL) and their roots in novel learning theories, empirical methodologies for their design or evaluation, stand-alone and web-based solutions and maker spaces, and also fostering entrepreneurship and increasing business startup ideas. It brought together researchers and developers from industry, the education field and the academic world to report on the latest scientific research, technical advances and methodologies.

This full-color handbook is a quick-reference guide to all aspects of documentation for every nursing care situation. It covers current documentation systems and formats, including computerized documentation, and features scores of sample filled-in forms and in-text narrative notes illustrating everything from everyday occurrences to emergency situations. Coverage includes timesaving strategies for admission-to-discharge documentation in acute, outpatient, rehabilitation, long-term, and home care environments and special documentation practices for selected clinical specialties: critical care, emergency, perioperative, maternal-neonatal, and psychiatric. The book includes advice on legal safeguards, dangerous abbreviations, and compliance with HIPAA guidelines and JCAHO requirements.

The COVID-19 pandemic has increased the focus on health informatics and healthcare technology

for policy makers and healthcare professionals worldwide. This book contains the 110 papers (from 160 submissions) accepted for the 18th annual International Conference on Informatics, Management, and Technology in Healthcare (ICIMTH 2020), held virtually in Athens, Greece, from 3 – 5 July 2020. The conference attracts scientists working in the field of Biomedical and Health Informatics from all continents, and this year it was held as a Virtual Conference, by means of teleconferencing, due to the COVID-19 pandemic and the consequent lockdown in many countries around the world. The call for papers for the conference started in December 2019, when signs of the new virus infection were not yet evident, so early submissions were on the usual topics as announced. But papers submitted after mid-March were mostly focused on the first results of the pandemic analysis with respect to informatics in different countries and with different perspectives of the spread of the virus and its influence on public health across the world. This book therefore includes papers on the topic of the COVID-19 pandemic in relation to informatics reporting from hospitals and institutions from around the world, including South Korea, Europe, and the USA. The book encompasses the field of biomedical and health informatics in a very broad framework, and the timely inclusion of papers on the current pandemic will make it of particular interest to all those involved in the provision of healthcare everywhere.

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Covering the full range of nursing interventions, Nursing Interventions Classification (NIC), 6th Edition provides a research-based clinical tool to help in selecting appropriate interventions. It standardizes and defines the knowledge base for nursing practice while effectively communicating the nature of nursing. More than 550 nursing interventions are provided - including 23 NEW labels. As the only comprehensive taxonomy of nursing-sensitive interventions available, this book is ideal for practicing nurses, nursing students, nursing administrators, and faculty seeking to enhance nursing curricula and improve nursing care. More than 550 research-based nursing intervention labels with nearly 13,000 specific activities Definition, list of activities, publication facts line, and background readings provided for each intervention. NIC Interventions Linked to 2012-2014 NANDA-I Diagnoses promotes clinical decision-making. New! Two-color design provides easy readability. 554 research-based nursing intervention labels with nearly 13,000 specific activities. NEW! 23 additional interventions include: Central Venous Access Device Management, Commendation, Healing Touch, Dementia Management: Wandering, Life Skills Enhancement, Diet Staging: Weight Loss Surgery, Stem Cell Infusion and many more. NEW! 133 revised interventions are provided for 49 specialties, including five new specialty core interventions. NEW! Updated list of estimated time and educational level has been expanded to cover every intervention included in the text.