inadequate, anxious, and guilty. However, the mother is able to adapt to this crisis. She demonstrates an ability to cope by learning and implementing new comforting skills for her child. The defining characteristics of the other two diagnoses require maladaptive characteristics that are clearly not demonstrated by these parents.

Outcomes Identification

The goal for outcomes identification is to establish priorities and select expected patient outcomes or goals. The nurse organizes information during assessment and diagnosis and clusters these data into categories to identify significant areas and makes one of the following decisions:

- No dysfunctional health problems are evident; health promotion is emphasized.
- Risk for dysfunctional health problems exists; interventions are needed for health promotion and illness prevention.
- Actual dysfunctional health problems are evident; interventions are needed for illness management, illness prevention, and health promotion.
- Specific outcomes are formulated to address the realistic patient- and family-focused goals.

Planning

After identifying specific patient- and family-focused goals, the nurse develops a care plan specific to the identified outcomes. The outcome is the projected or expected change in a patient's health status, clinical condition, or behavior that occurs after nursing interventions have been instituted. The care plan must be established before specific nursing interventions are developed and implemented.

Implementation

The implementation phase begins when the nurse puts the selected intervention into action and accumulates feedback data regarding its effects (or the patient's response to the intervention). The feedback returns in the form of observation and communication and provides a database on which to evaluate the outcome of the