

# Understanding the Difference: Observation, Assessment, and Diagnosis

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## INTRODUCTION

The College of Licensed Practical Nurses and Health Care Aides of Alberta (CLHA) has the authority under the *Health Professions Act* (HPA) to carry out its activities and govern Licensed Practical Nurses (LPNs)\* in a manner that protects and serves the public interest.

According to the *Code of Ethics for Licensed Practical Nurses*, LPNs are expected to respect the expertise of colleagues and share their own knowledge and skills. This info sheet informs LPNs of the differences between observing, assessing, and diagnosing clients and the responsibilities that different health professionals may have in collaborative practice.

## Defining the Difference: Observing, Assessing, and Diagnosing

Health professionals such as LPNs, Health Care Aides (HCAs), and physicians perform different activities in client care, including observation, assessment, and diagnosis.\* These distinct roles are important and require different skills. Sometimes a health professional can perform more than one of these roles, provided they are authorized and competent to do so.

LPNs carry out observation, assessment, and nursing diagnosis but are not authorized to make a medical diagnosis.

## Observation

LPNs perform client observation as a key aspect of the nursing process. Observation involves using sight, hearing, smell, and touch to monitor changes in a client's health or social well-being. It includes objective and subjective observations.<sup>1</sup> Regular observation and documentation support client assessments and help identify changes in the client's condition.

Proper observation, documentation, and reporting of objective and subjective data are essential in optimizing client care. If a client's condition is observed to be abnormal or outside the client's baseline, the LPN should conduct an assessment and report all relevant findings for further investigation.

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\*In this document, "LPN(s)" has the same meaning as "regulated member(s)" in the *Health Professions Act*.

\* In this document, diagnosis refers to medical diagnosis and both terms are used interchangeably.

Some examples of observations LPNs may perform include but are not limited to:

- colour, warmth, circulation, and movement;
- signs and symptoms of infection (redness, swelling, warmth, or discharge);
- orientation (person, place, and time);
- odour (urine, feces, wounds, etc.);
- pupils equal and reactive to light;
- signs of neglect;
- changes in the client's behaviour or health status;
- any adverse events, including rashes and other allergic reactions;
- unsafe conditions or environment; and
- gait and mobility.

#### **LPN Collaboration with Members of the Healthcare Team**

LPNs may observe clients directly or rely on other health professionals, like HCAs, to report changes in a client's health condition. When an LPN becomes aware of an abnormal finding, they must perform an assessment on the client and then document and communicate their observations, assessment findings, and actions taken. This collaboration ensures that important information reaches the right health professional at the right time to provide the best care for clients.

### **Assessment**

A client assessment involves organizing and analyzing information about a client's condition. This can be done using the client's medical history, test results, observation findings, daily living tasks assessment, mental health evaluation, and available support resources (such as family, monetary, housing, disability help, and home care).<sup>ii</sup> Only authorized health professionals, such as nurses, psychologists, occupational therapists, etc., can perform client assessments. For example, LPNs are authorized to perform assessments using their nursing knowledge, skill, and judgment. This is called a nursing assessment.

A nursing assessment involves using the client's gathered health information to understand their overall health, symptoms, and concerns. This process includes evaluating the client's individual physiological, psychological, sociological, and spiritual needs.<sup>iii</sup> Timely and detailed nursing assessments are key skills LPNs demonstrate in their practice. LPNs are expected to use critical thinking, clinical judgement, and decision-making skills to evaluate their assessments and determine the next steps of a client's care. This includes documenting and reporting abnormal findings to the most responsible health provider.

### **Collaboration Between Other Health Professionals**

When providing care, different members of the healthcare team work together for the client's well-being. For example, HCAs play a vital role by observing and monitoring clients and promptly reporting any changes in the client's condition to the rest of the team. LPNs observe, assess, make a nursing diagnosis, and share important information about the client's health. Health professionals such as physicians or nurse practitioners (NPs) diagnose diseases, conditions, and injuries and make treatment plans. By collaborating, the healthcare team ensures the client receives safe and holistic care.

## **Diagnosis**

A diagnosis, also known as a medical diagnosis, identifies a disease, injury, or condition based on presenting signs and symptoms. Authorized health professionals like physicians, NPs, dentists, and physician assistants conduct this process by investigating observations, assessments, and diagnostic tests to distinguish one condition from others. Diagnosis aims to determine the cause of a client's symptoms (e.g., pneumonia, diabetes) and guides the treatment plan and medical interventions.<sup>iv</sup>

LPNs are not authorized to make a medical diagnosis. However, they can make a nursing diagnosis.

### **Nursing Diagnosis**

A nursing diagnosis is a clinical judgment concerning a human response (actual or potential) to health conditions/life processes. It focuses on the client's response to illness, treatment, or life situations. It aims to provide an understanding of the client's needs, enabling nurses to design and implement tailored care plans.<sup>v</sup> For example, a client assessed to have dyspnea, coughing, and wheezing can receive a nursing diagnosis of ineffective airway clearance related to decreased lung expansion. This nursing diagnosis is then used to plan a nursing intervention. A nursing diagnosis may complement a medical diagnosis by providing information about the client's impairments and challenges, but it does not replace a medical diagnosis.

The following table summarizes the differences between observation, assessment, and diagnosis.

	<b>Observation</b>	<b>Assessment</b>	<b>Diagnosis</b>
<b>Purpose</b>	To monitor and detect changes or abnormal findings in the client’s state or condition. The information gathered helps inform the next steps in the client’s healthcare journey.	Involves organizing and analyzing information to learn more about the client’s overall health, symptoms, and concerns.	To identify a disease or condition.
<b>Information Collected</b>	Objective and subjective data on the client’s condition, such as: <ul style="list-style-type: none"> <li>the information collected from readings such as vital signs, gait, mobility, etc.</li> <li>the presenting signs and symptoms of the client that can be seen, heard, smelled, and touched.</li> </ul>	Detailed information from the client's medical history, assessment, test results, etc., including observations and the client's individual physiological, psychological, sociological, and spiritual needs.	The information collected during observation and assessment as well as the client's physical, mental, and psychosocial condition.
<b>Who Can Perform It</b>	A range of trained health professionals, including LPNs and HCAs.	Health professionals with specific skills, knowledge, critical thinking, and clinical judgment, such as LPNs or physicians.	Specific health professionals authorized by law to diagnose. Examples are physicians, NPs, optometrists, and physician assistants.
<b>Outcome</b>	Contributes to continuity of care and holistic care by providing information related to changes in the client’s condition that can be further investigated.	Evaluates information for the purpose of making a nursing diagnosis and/or developing or updating a client’s care plan. It may also inform next steps in the treatment or discharge plan.	Identifies a disease or condition, which helps health professionals determine a treatment plan, track progression, and understand the prognosis.

## CONCLUSION

This info sheet describes the different activities in client care, such as observation, assessment, and diagnosis, performed by different members of the healthcare team. This understanding promotes collaboration, which leads to better client care.

Documents are updated frequently. For the most current version and access to related documents and resources, please visit the Knowledge Hub on clha.com.

If after reading this document you have questions about this topic, please contact the CLHA's Professional Practice Team at [practice@clha.com](mailto:practice@clha.com), 780-484-8886 or 1-800-661-5877 (toll free in Alberta).

## REFERENCES

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<sup>i</sup> Azilo Training. (2019). The Importance of Observation in Health and Social Care Settings. [The Importance of Observation in Health and Social Care Settings | AziloTraining](#)

<sup>ii</sup> National Cancer Institute. (2015). [Definition of assessment - NCI Dictionary of Cancer Terms - NCI](#)

<sup>iii</sup> National Library of Medicine (NIH). Toney-Butler, T.J., & Unison-Pace, W.J. Nursing Admission Assessment and Examination. (2023). [Nursing Admission Assessment and Examination - StatPearls - NCBI Bookshelf \(nih.gov\)](#)

<sup>iv</sup> Government of Alberta. *Health Professions Act (HPA)*. Schedule 21. Professions of Physicians, Surgeons, Osteopaths and Physician Assistants. Section 3(1)(a-e). [H07.pdf \(alberta.ca\)](#)