A tabulated glossary for use with HoNOS 65+

A few guidelines to remember

1. Rating applies to reference period only
2. Use all available information. Base content on problems - not diagnosis.
3. Start at Item 1 and rate in order so as to rate the problem/symptom once only thereby avoiding overlap.
4. Use your clinical judgement to make rating .
5. Rate the most severe point/most severe symptom or problem during the reference period Look at **all** rows and score which is worst.
6. **Summary of scores in general**

   0 No problem

   1 Minor problem – usually requiring no action (sub threshold)

   2 Mild problem but definitely present

   3 Moderate

   4 Severe

   9 Not known (but avoid if possible)

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SCALE 1. BEHAVIOURAL DISTURBANCE

- ***Can be due to any cause***

	No problem	**Minor** (Not requiring any specific action)	**Mild**	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
a) Overactive	Nil	Slight overactivity	Significant overactivity	Persistent overactivity	Severe overactivity
b) Aggressive	Nil	Occasionally irritable/quarrels	Verbal threats - pushing-pestering interfering *(e.g. aggressive gestures)*	Frequent verbal threats/physical aggression to others	At least 1 serious physical attack/persistent and serious threatening behaviour
c) Disruptive or destructive to persons object	Nil	Nil	Minor destruction to property *(e.g. broken cup/window)*	Increased destruction to property (more serious)	Serious/persistent destruction *(e.g. fire-setting)*
d) Restlessness	Nil	Occasional	Intermittent	Frequent	Virtually constant
e) Agitation	Nil	Nil	Significant agitation	Persistent	Severe agitation
f) Uncooperative or resistive	Nil	Calm & co-operative in general	Uncooperative at times requiring persuasion & encouragement	Significant & frequent non-co-operation	Severe non-compliant or resistive behaviour
g) Wandering	Nil	Nil/occasional	Intermittent (day **or** night)	More frequent (day **and** night)	Virtually constant
h) Inappropriate & disinhibited behaviour (e.g. sexual)					Deliberate (e.g. urination &/or defecation)
j) Inappropriate vocalisation e.g. screaming, grunting, whimpering	Nil	Occasional	Intermittent	Persistent	Severe and intolerable to others
k) Bizarre behaviour e.g. posturing					
l) Other					

SCALE 2. NON-ACCIDENTAL SELF-INJURY

- ***Do not consider risk of future self-harm but only the risk within the reference period. Include both parasuicide and suicidal attempts***
- ***The issue of intent is part of current risk assessment although difficult to assess. In the absence of evidence to the contrary assume that the results of self harm were all intended. Do NOT rate future risk- only risk during the past reference period***

	No problem	**Minor**	**Mild**	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
a) Thoughts/Ideas	Nil	Rather be dead –wanting to be dead but no thoughts of self harm	Occasional thoughts of self harm (active or passive)	Frequent thoughts of self-harm including planning	Persistent and serious thoughts of self- harm
b) Intent	Nil	Nil	Mild (*e.g. not taking avoiding actions in potentially life threatening situations)*	Moderate risk in reference period/moderate intent. Preparing behaviour *(e.g. collecting tablets)*	Serious risk of self-harm in reference period
c) Acts	Nil	Nil	Nil	Nil	At least one attempt at self-harm in reference period

SCALE 3. PROBLEM-DRINKING OR DRUG-USE

	No problem	**Minor** (some over indulgence but within social norm)	**Mild** (not a serious problem)	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
a) Craving & Tolerance	Nil	Nil	Mild degree	Marked craving or dependence	Severe craving and dependence
b) Priority given to these	Nil	Nil	More frequent	Persistent	Total
c) Impaired control	Nil	Can control	Some loss of control	Moderate loss of control	Severe/persistent loss of control
d) Frequency of intoxication	Nil	Insignificant	More regular - approx. 2-3 times a week	More frequent - approx. 4-5 times a week	Persistent - daily
e)Other risk taking e.g. drink/driving	Nil	Nil	More frequent	Significant	Severe
f) Temporary effects	Nil	Rarely	Occasional hangover	Frequent hangovers	Incapacitated from alcohol/drug problems -

SCALE 4. COGNITIVE PROBLEMS

- ***associated with any disorder***

	No problem 0	Minor 1	Mild 2	Moderate 3	Severe 4
a) Memory	Nil	A degree of forgetfulness but can learn new material	Definite problems remembering new information *(e.g. for names or recollection of recent events)* Deficit interferes with everyday activities Some difficulty finding way in new or unfamiliar surroundings	Cannot retain new information (only retains highly learned material)	Severe impairment *(e.g. Only fragments remain; loss of distant as well as recent information; unable to learn new information unable to recognise or name close friends/relatives.)*
b) Orientation	Nil	Some difficulty with orientation to time	Frequently disorientated to time	Usually disorientated to time and often to place	Consistently disorientated to time and place and sometimes to person
c) Language	Nil	No difficulties with use of language	Can deal with simple verbal information but some difficulty with understanding Poor expression of more complex language	Major difficulties with language (expressive and/or receptive).	No effective communication possible through language - inaccessible to speech

SCALE 5. PROBLEMS RELATED TO PHYSICAL ILLNESS/DISABILITY

from any cause

	No problem	**Minor health problem**	**Mild Restriction in activities or mobility**	**Moderate Restriction in Activities**	**Severe Major health problems with severe restriction of activities**
	0	**1**	**2**	**3**	**4**
a) Physical health	Nil	e.g. old bruising from falls etc, which will clear rapidly (*e.g. patient in remission from long term illness i.e. arthritis)*	Mild chest infection or UTI Some degrees of loss of independence	More serious chest infection or UTI + incontinence	Major infections leading to being bed-ridden
b) Mobility	Nil	Some restriction	Restricted walking distance (without aids)	Walks only with aid or help	Chair/bed-ridden
c) Sensory impairment	Nil	Some impairment but able to function effectively (*e.g. glasses or hearing aid)*	Impairment of sight or hearing despite aids (*e.g. glasses or hearing aid)*	Moderate impairment	Severe impairment – (*e.g. registered blind and deaf)*
d) Falls	Nil	Nil	Possible or low risk of falls with no falls to date (unsteady)	Significant risk of falling or 1 or more falls	High risk of falls with 1 or more falls due to physical illness/disability
e) Side effects of medication	Nil	Nil	Mild	Moderate degree	Severe
f) Pain due to physical illness	Nil	Nil	Mild degree of pain	Moderate degree of pain	Severe pain/problems associated with pain
g) Injury associated with drugs, alcohol, self-injury, or accident	Nil	Nil	Mild	Moderate e.g. Cirrhosis	Severe Impaired level of consciousness e.g. stupor
h) Other *(e.g. speech affected by dental problems)*					

SCALE 6. PROBLEMS ASSOCIATED WITH HALLUCINATIONS AND/OR DELUSIONS (OR FALSE BELIEFS)

irrespective of diagnosis

	No problem	**Minor**	**Mild - Clinical Problem**	**Moderate - Clinical Problem**	**Severe - Clinical problem**
	0	**1**	**2**	**3**	**4**
a) Delusions	Nil	Some odd/eccentric beliefs. Harmless but not in keeping with cultural norms	Present but little distress to self or others	• Marked preoccupation with delusions or hallucinations causing significant distress to self or others	• Mental state and behaviour seriously affected by delusions or hallucinations • Has major impact on patient or others
b) Hallucinations	Nil	Nil	Present but little distress	As above	As above
c) Thought disorder	Nil	Loosening of association	Mild thought disorder	Moderate thought disorder	Incomprehensible, irrelevant

SCALE 7. PROBLEMS WITH DEPRESSIVE SYMPTOMS

	No problem	**Minor**	**Mild**	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
Mood disturbance *(depressed mood and symptoms associated with depressed mood in any disorder)*	Nil	Gloomy or minor or transient changes in mood	Definite depression on subjective and objective measures (*e.g. loss of interest, pleasure or self-esteem, lacking in energy or feelings of guilt)*	Marked depressive symptoms (on subjective or objective grounds)	Severe depressive symptoms on subjective or objective grounds (*e.g. preoccupation with guilt and worthlessness or withdrawn due to severe loss of interest; profound loss of interest of pleasure)*

SCALE 8. OTHER MENTAL AND BEHAVIOURAL PROBLEMS

- ***Rate single most severe clinical problem not rated in scales 1-7***
  - ***A) Phobias,***
  - ***B) Anxiety and Panic***
  - ***C) Obsessive-Compulsive***
  - ***D) Mental Strain and Tension***
  - ***E) Dissociative or conversion problems***
  - ***F) Somatoform - persisting physical complaints of mainly psychological origin (with little evidence of physical disease) e.g. Hypochondriasis***
  - ***G) Eating - over/under***
  - ***H) Sleep – Hypersomnia / Insomnia***
  - ***I) Sexual***
  - ***J) Other - such as elation - expansive mood - problems not specified elsewhere***

	No problem	**Minor** (Requiring little or no action)	**Mild** (a problem is clinically present)	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
a) Severity of symptoms.	Nil	Non clinical problems	At a mild level - patient still interacting and not withdrawn	Problem is at a moderate/significant level (symptoms more marked)	Symptoms severe
b) Frequency	Nil	Infrequent	Intermittent	More frequent	Symptoms persistent
c) Degree of control.	Nil	Well controlled	Patient maintains degree of control.	Beginning to lack control	Dominates or seriously affecting most activities
d) Degree of distress (to self only)	Nil	Probably not	Not unduly distressed	Symptoms more distressing	Severe distress

SCALE 9. PROBLEMS WITH SOCIAL OR SUPPORTIVE RELATIONSHIPS

Identified by or apparent to patient, carers or others such as residential staff

a) Active or passive withdrawal from relationships (as judged by *quality or quantity* of communications skills*)*
b) Non supportive relationships (patient unable to gain emotional support
(*e.g. because they are over friendly, because they are unable to interpret language effectively)*
c) Destructive/Self-damaging Relationships
(e.g. *because of personal problems and thereby having difficulty in maintaining relationships or making useful allies)*

	No problem	**Minor**	**Mild**	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
a) Degree of active/ passive withdrawal from relationships and conflicts.	Nil	May be solitary but self-sufficient and competent when with others.	Evidence of definite problems in making, sustaining or adapting to supportive relationships (*e.g. due to controlling manner or arising out of difficult /exploitative or abusive relationship with carers)* Difficulties reported by patient or evident to others	Significant and moderate degree of conflict identified by patient or others.	Severe difficulties with relationships. (*e.g. isolation / withdrawal /conflict or abuse).* Major tensions and stresses (*e.g. threatening breakdown of relationships).*
b) Frequency.	Nil	Satisfied with level of interest	Intermittent problem or variable problem with relationships.	Persistent problem within relationship leading to some withdrawal.	Persistent and ongoing
c) Distress	Nil	Nil	Not very distressed (mild).	Distressed (Significant) (the patient and/or others)	Very distressed

SCALE 10. PROBLEMS WITH ACTIVITIES OF DAILY LIVING

Rate current overall level of actual performance or functioning (not potential competence). Include any lack of motivation. Consider:
Personal activities of daily living i.e. dressing, washing, toiletting, eating **Domestic** activities of daily living i.e. shopping, housework, cooking, finances

	No problem	**Minor** (No significant or adverse consequences)	**Mild**	**Moderate**	**Severe**
	0	**1**	**2**	**3**	**4**
Personal and domestic activities of daily living	Good ability to function effectively.	Some deficits but able to cope effectively (e.g. *untidy, mildly disorganised)*	May require prompting. Significant but mild deficits affecting function. Problems noted in domestic ADL (*e.g. problems organising and making a meal. Problems with financial judgement)*	Definite problems in both personal and domestic ADL. (*e.g. needs some supervision with dressing and eating, occasional urinary incontinence, unable to prepare and make a meal.)*	Severe incapacity in nearly all areas in both personal and domestic ADL (*e.g. full supervision required with dressing and eating, frequent urinary and faecal incontinence*.)

SCALE 11. OVERALL PROBLEMS WITH LIVING CONDITIONS

Consider the degree to which the patient's living conditions impact on their intact skills and abilities. Consider specifically:

- ***a) Basic provisions i.e. heat, light, hygiene, cooking facilities***
- ***b) Relationship with relatives, helpful neighbours, others***
- ***c) Choices available or degree of opportunity to improve motivation (e.g. to facilitate use of existing skills and develop new ones), privacy - cooking, talents***
- ***d) Preferences and degree of satisfaction with home***
- ***e) Staff - numbers (trained), quality, experience, relationship to staff, knowledge of patient's ability.***

	No problem (Accommodation is acceptable & unrestricted. Autonomy achieved)	**Minor or transient problem** (Reasonably acceptable but less than full autonomy)	**Mild problems** (Moderate restriction of environment - may be risky to patient significant problems with 1 or more aspects)	**Moderate** **(Distressing & multiple problems with accommodation** causing substantial restriction, risk of injury, etc)	**Severe** **(Accommodation is** unacceptable, causing severe restriction, high risk of injury, etc)
	0	**1**	**2**	**3**	**4**
Objective view of patient's environment	Very good	Fair *e.g. poor decorative order/smelly/dirty. No fundamental deficiencies*	Some significant problems with accommodation or aids and adaptations. Basic provisions present	Poor - Absence of 1 or more basic necessities *e.g. poor cooking facilities*	Severe problems. Very poor. Roofless - Severe *e.g. living conditions intolerable*

SCALE 12. PROBLEMS WITH WORK AND LEISURE ACTIVITIES - QUALITY OF DAYTIME ENVIRONMENT.

Rate overall level of problems. Rate for environment in reference period only. Consider

a) Arrangements for transport
b) Staff/Carers/Professionals - numbers (trained), quality, experience, relationship to staff, knowledge of patient's ability
c) Patients <u>occupation</u> during the day
d) ***Rate for environment in reference period only***

	No problem (Autonomy achieved or maximised)	**Minor or temporary problems** (Less full autonomy)	**Mild restriction**	**Moderate restriction**	**Severe restriction** (Patient severely neglected. Min conditions with no constructive activities)
	0	**1**	**2**	**3**	**4**
a) Activities available - educational courses, libraries, day centres, drop-ins	Very good opportunities available / accessible	Activities available but not at convenient times etc	Limited choice of opportunities *(e.g. insufficient carer/professional support, or limited day support)*	Deficiency in skilled services and support available to optimise skills. Little opportunity to develop new skills	Lack of any effective opportunity for day time activities
b) Degree of co-operation of pt	Total co-operation	Patient reluctant or had difficulty making use of facilities	Patient sometimes unwilling or unable to use facilities	Patient often unwilling or unable to use facilities	Patient refuses to or is always unable to use facilities