Richmond Agitation Sedation Scale (RASS) *

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening	
		(eye-opening/eye contact) to voice (≥10 seconds)	\ Verbal
-2	Light sedation	Briefly awakens with eye contact to voice (<10 seconds)	Stimulation
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)	
-4	Deep sedation	No response to voice, but movement or eye opening	
		to physical stimulation	Physical Stimulation
-5	Unarousable	No response to <i>voice or physical</i> stimulation	Cumulation

Procedure for RASS Assessment

1. Observe patient

a. Patient is alert, restless, or agitated. (score 0 to +4)

2. If not alert, state patient's name and say to open eyes and look at speaker.

- b. Patient awakens with sustained eye opening and eye contact. (score –1)
- c. Patient awakens with eye opening and eye contact, but not sustained. (score -2)
- d. Patient has any movement in response to voice but no eye contact. (score -3)
- 3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
 - e. Patient has any movement to physical stimulation. (score –4)
 - f. Patient has no response to any stimulation. (score –5)

^{*} Sessler CN, Gosnell M, Grap MJ, Brophy GT, O'Neal PV, Keane KA et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care patients. Am J Respir Crit Care Med 2002; 166:1338-1344.

^{*} Ely EW, Truman B, Shintani A, Thomason JWW, Wheeler AP, Gordon S et al. Monitoring sedation status over time in ICU patients: the reliability and validity of the Richmond Agitation Scale (RASS). JAMA 2003; 289:2983-2991.