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 Stimulation
-2	Light sedation	Briefly awakens with eye contact to *voice* **(<10 seconds)**	
-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 *voice or physical* stimulation	

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 Sedation Scale (RASS). JAMA 2003; 289:2983-2991.