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 <i>voice</i> (≥10 seconds)	Verbal
-2	Light sedation	Briefly awakens with eye contact to <i>voice</i> (<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 <i>physical</i> 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 sustain	ed. (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 shaking shoulder and/or rubbing sternum.	by	
	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.