APPENDIX D: 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, 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 (< 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: 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	
- Patient awakens with sustained eye opening and eye contact.	Score -1
- Patient awakens with eye opening and eye contact, but not sustained.	Score -2
- 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.	
- Patient has any movement to physical stimulation.	Score -4
- 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.