How to use the Richmond Agitation Sedation Scale (RASS)

Background information

- RASS scores are closely associated with GCS and CAM-ICU assessments.
- Pain, agitation and delirium are all interlinked.
- Patients at RASS -2 to +4 should be assessed for delirium.
- RASS scoring does not apply if the patient is asleep (recorded as S)
- CAM-ICU is not applicable for RASS -4 and -5. At -3, it is clinician judgement whether patient is conscious enough to participate in the assessment.

Step 1 – observe the patient

- Is the patient alert and calm? Yes → score is 0
- Is the patient restless or agitated? Yes → refer to descriptors to obtain score ranging +1 to +4

Step 2 – attempt to rouse the patient verbally – address the patient by his/her name and ask them to open their eyes and look at you

- Patient looks at you with eye contact for more than 10 seconds → score is -1
- Patient looks at you with eye contact but sustained for less than 10 seconds → score is -2
- Patient moves in response to voice but makes no eye contact → score is -3

Step 3 – attempt to rouse the patient physically e.g. shake the patient's shoulder

- Patient moves in response to physical stimuli → score is -4
- Patient does not respond to physical stimuli → score is -5

+4	Combative; overtly violent; immediate danger to staff	
+3	Very agitated; pulls or removes tubes/catheters; aggressive	
+2	Agitated; frequent non-purposeful movements; fights ventilator	
+1	Restless; anxious but not aggressive/vigorous	
0	Alert and calm	
-1	Drowsy; not fully alert but sustained awakening; eye contact to voice >10 secs	VOICE
-2	Light sedation; briefly awakens to voice with eye contact <10 secs	
-3	Moderate sedation; movement or eye opening to voice but no eye contact	
-4	Deep sedation; no response to voice; movement or eye opening to physical stimulation	TOUCH
-5	Unrousable; no response to voice or physical stimulation	