northern health
the northern way of caring

Facility

Richmond Agitation Sedation Scale (RASS)

 PATIENT LABEL

Term	Score	Description
+ 4	Combative	Overly combative or violent. Immediate danger to staff.
+ 3	Very Agitated	Pulls/removes tubes or catheters. Has aggressive behavior toward staff.
+ 2	Agitated	Frequent non-purposeful movement.
+ 1	Restless	Anxious or apprehensive but movements not aggressive or vigorous.
0	Alert and Calm	Alert and Calm
- 1	Drowsy	Not fully alert but has sustained (greater than 10 sec.) awakening with eye contact to voice.
- 2	Light Sedation	Briefly (less than 10 sec.) awakens with eye contact to voice.
- 3	Moderate Sedation	Any movement (but no eye contact) to voice.
- 4	Deep Sedation	No response to voice but any movement to physical stimulation.
- 5	Unrousable	No response to voice or physical stimulation.

Procedure for RASS Assessment

Step	Procedure	Score
1	Observe patient. • Patient is alert, restless or agitated.	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. • Patient awakens with eye opening and eye contact but not sustained. • Patient has any movement in response to voice but no eye contact.	 - 1 - 2 - 3
3	If patient does not respond to voice, physically stimulate patient by shaking shoulder and/or rubbing sternum*: • Patient has any movement to physical stimulation • Patient has no response to any stimulation.	 - 4 - 5

**** Rubbing the sternum is not appropriate for palliative care patient assessment and is not recommended.***