Richmond Agitation-Sedation Scale (RASS)

+4	**Combative**	Combative, violent, immediate danger to staff
+3	**Very agitated**	Pulls or removes tube(s) or catheter(s); aggressive
+2	**Agitated**	Frequent nonpurposeful movement, fights ventilator
+1	**Restless**	Anxious, apprehensive but movements are not aggressive or vigorous
0	**Alert and calm**	
-1	**Drowsy**	Not fully alert, but has sustained awakening to voice (eye opening & contact > 10 sec)
-2	**Light sedation**	Briefly awakens to voice (eye opening & contact < 10 sec)
-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
-5	**Unarousable**	No response to voice or physical stimulation

Sessler, et al., Am J Repir Crit Care Med 2002, 166: 1338-1344
Ely, et al., JAMA 2003; 286, 2983-2991

Sedation and Delirium Assessments: A Two Step Approach

Step One: Sedation Assessment (*RASS)*

If RASS is -4 or -5, then **Stop** & **Reassess** patient at later time
If RASS is above - 4 (-3 through +4) then **Proceed to Step 2**

Step Two: Delirium Assessment *(CAM-ICU)*

Feature 1: Acute onset of mental status changes or a fluctuating course

And

Feature 2: Inattention

And

Feature 3: Disorganized Thinking

Or

Feature 4: Altered Level of Consciousness

= DELIRIUM

Ely, JAMA 2001; 286, 2703-2710.
Ely, Crit Car Med 2001: 29,1370-1379.
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Feature 1: Acute Onset or Fluctuating Course

** Feature 1 is **positive** if either question is answered *yes.*

A. Is there an acute change from mental status baseline?
B. Did the patient's mental status fluctuate during the past 24hrs as evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment?

Feature 2: Inattention

** Feature 2 is **positive** if ASE score is less than 8.

Assess using the **Attention Screening Examination (ASE) – Letters or Pictures.** Attempt ASE Letters first. If pt is able to perform this test and the score is clear, record this score and move to Feature 3. If pt is unable to perform this test or the score is unclear, perform the ASE Pictures. If you perform both tests, use the ASE pictures results to score the Feature.

ASE Letters: Auditory/Random Letter "A" Test
Directions: Say to the patient, *"I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand."* Read letters from the following letter list in a normal tone.

S A V E A H A A R T

Scoring: Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."

ASE Pictures: Visual/Picture Recognition
Directions and Scoring are located on the picture packet

Feature 3: Disorganized Thinking

Feature 3 is **positive if the combined (Questions+Command) score is less than 4.

Yes/No Questions Use either Set A or Set B, alternate on consecutive days if necessary.

Set A	Set B
1. Will a stone float on water?	1. Will a leaf float on water?
2. Are there fish in the sea?	2. Are there elephants in the sea?
3. Does one pound weigh more than two pounds?	3. Do two pounds weigh more than one?
4. Can you use a hammer to pound a nail?	4. Can you use a hammer cut wood?

Score: Patient earns 1 pt for each correct answer out of 4.

Command
Say to patient: *"Hold up this many fingers"* (Examiner holds two fingers in front of patient) *"Now do the same thing with the other hand"* (Not repeating the number of fingers).

Score: Patient earns 1 point if able to successfully complete the entire command.

Feature 4: Altered Level of Consciousness

Feature 4 is **positive if patient's current level of consciousness is anything other than **alert** (e.g., RASS other than "0" at time of assessment).

Feature 1: Acute Onset or Fluctuating Course

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A. Is there an acute change from mental status baseline?
B. Did the patient's mental status fluctuate during the past 24hrs as evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment?

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