

Richmond Agitation-Sedation Scale

What:

- Scale used to measure agitation or sedation levels in patients.
- Assessment and documentation completed by RNs.

Who:

- Can be used on all hospitalized patients, however, most frequently used in mechanically ventilated patients.

Why:

- Helps avoid over or under sedation of patients.
- As opposed to the GCS, the RASS is not limited to patients with intracranial processes.

When:

- A RASS should be completed based on providers orders and with any titration of sedation.
- RASS is a separate order from GCS or neuro checks.

RICHMOND AGITATION-SEDATION SCALE (RASS)

STEP 1

Level of Consciousness Assessment

Scale	Label	Description
+4	COMBATIVE	Combative, violent, immediate danger to staff
+3	VERY AGITATED	Pulls to remove tubes or catheters; aggressive
+2	AGITATED	Frequent non-purposeful movement, fights ventilator
+1	RESTLESS	Anxious, apprehensive, movements not aggressive
0	ALERT & CALM	Spontaneously pays attention to caregiver
-1	DROWSY	Not fully alert, but has sustained awakening to voice (eye opening & contact >10 sec)
-2	LIGHT SEDATION	Briefly awakens to voice (eyes open & contact <10 sec)
-3	MODERATE SEDATION	Movement or eye opening to voice (no eye contact)
If RASS is \geq -3 proceed to CAM-ICU (Is patient CAM-ICU positive or negative?)		
-4	DEEP SEDATION	No response to voice, but movement or eye opening to physical stimulation
-5	UNAROUSABLE	No response to voice or physical stimulation
If RASS is -4 or -5 → STOP (patient unconscious), RECHECK later		

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