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

Linking Sedation and Delirium Monitoring: A Two Step Approach to Assess Consciousness

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 Assesmment *(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.

[redacted]

A. Is there evidence of an **acute change** in mental status from the baseline?
or
B. Did the (abnormal) behavior **fluctuate** during the past 24 hours, that is, tend to come and go, or increase and decrease in severity as evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment?

[redacted]

Did the patient have difficulty focusing attention as evidenced by a score of **less than 8** on either the visual or auditory component of the **Attention Screening Examination (ASE)**?

ASE – Visual and Auditory:

1. Visual: Picture Recognition (Refer to picture packet)

2. Auditory: Vigilance "A" Random Letter 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 H E V A A R A 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."

[redacted]

Is there evidence of disorganized or incoherent thinking as evidenced by ***incorrect*** **answers to 2 or more of the 4** questions and/or inability to follow the commands?
Questions:

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 pound?
4. Can you use a hammer to pound a nail?	4. Can you use a hammer to cut wood?

Other:
1. Are you having any unclear thinking?
2. Hold up this many fingers. (Examiner holds two fingers in front of patient).
3. Now do the same thing with the other hand (not repeating the # of fingers).

[redacted]

Is the patient's LOC anything *other than alert?* (e.g., RASS other than "0" at time of assessment):

Alert spontaneously fully aware of environment and interacts appropriately
Vigilant hyperalert
Lethargic drowsy but easily aroused, unaware of some elements in the environment, or not spontaneously interacting appropriately with the interviewer; becomes fully aware and appropriately interactive when prodded minimally
Stupor becomes incompletely aware when prodded strongly; can be aroused only by vigorous and repeated stimuli, and as soon as the stimulus ceases, stuporous subject lapse back into the unresponsive state