Assessment of the level of sedation

The RASS score

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The Richmond agitation and sedation scale (RASS)

- There are lots of ways to assess sedation in critical care.
- In our unit we use the RASS scoring system.
- This allows us to communicate with each other about how sedated the patient is and what we are aiming for
- By recording the score on the chart we can also see trends in how the patient has been sedated.
- There is a video lasting about 2 minutes describing this on our web site on the page about procedures and examination
- (https://salfordcriticalcare.org/videos-of-practical-procedures/)
- This section also has descriptions of the Glasgow Coma Scale and how to assess the patient for delirium (CAM-ICU)

The scale +4 to -5 is shown below

RASS score

Richmond Agitation & Sedation Scale				CAM-ICU
Score	Description			
+4	Combative	Violent, immediate danger to staff		RASS ≥ -2 Proceed to CAM-ICU assessment
+3	Very agitated	Pulls at or removes tubes, aggressive		
+2	Agitated	Frequent non-purposeful movements, fights ventilator		
+1	Restless	Anxious, apprehensive but movements not aggressive or vigorous		
0	Alert & calm			
-1	Drowsy	Not fully alert, sustained awakening to voice (eye opening & contact >10 secs)	Voice	
-2	Light sedation	Briefly awakens to voice (eye opening & contact < 10 secs)		
-3	Moderate sedation	Movement or eye-opening to voice (no eye contact)		RASS < -2 STOP Recheck later
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation	Touch	
-5	Un-rousable	No response to voice or physical stimulation		

How to do the scoring

- Positive scores of +1 to +4 are based on observing the patient.
- Negative scores, when the patient is not fully alert are done by talking to the patient first to see if they respond 9(-1 to -3).
- If they then don’t respond to voice (-4 to -5) we would assess if they respond to touch.
- The results of the score should be recorded on observation chart.

Management of the RASS score

- The medical staff should prescribe the score to aim for. This should be done in writing on the observation chart but often it's a verbal communication.
- If the patient is over sedated, the infusions of sedatives can be reduced or stopped.
- If the patient is under sedated, a 1 to 2ml bolus of sedation is given and the rate of the infusion is increased, normally by a couple of ml/hr.