AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Validated and Reliable Sedation Assessment Scales

Follow the Society of Critical Care Medicine's (SCCM's) 2013 Pain, Agitation, and Delirium (PAD) Guidelines to use either of the two scales below to routinely assess depth and quality of sedation in all adult patients in the ICU.

Sedation-Agitation Scale (SAS)

Score	State	Behavior
7	Dangerous Agitation	Pulls at ET tube, climbs over bedrail, strikes at staff, thrashes side-to-side
6	Very Agitated	Does not calm down despite frequent verbal reminders, requires physical restraints
5	Agitated	Anxious or mildly agitated, attempts to sit up, calms down after verbal instructions
4	Calm and Cooperative	Calm, awakens easily, follows commands
3	Sedated	Difficult to arouse, **awakens** to verbal stimuli or gentle shaking but drifts off
2	Very Sedated	Arouses to physical stimuli but **does not communicate** or follow commands
1	Unarousable	Minimal/no response to noxious stimuli, does not communicate or follow commands

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description
+4	Combative	Overtly combative or 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 but movements not aggressive, vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert but has sustained awakening (>10 seconds) with eye contact to voice
-2	Light Sedation	Briefly awakens (<10 seconds) with eye contact to voice
-3	Moderate Sedation	Any movement to voice but no eye contact
-4	Deep Sedation	No response to voice but any movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation