RASS and CAM-ICU Worksheet

Step One: Sedation Assessment

The Richmond Agitation and Sedation Scale: The RASS*

<table>
<thead>
<tr>
<th>Score</th>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
<td>Overtly combative, violent, immediate danger to staff</td>
</tr>
<tr>
<td>+3</td>
<td>Very agitated</td>
<td>Pulls or removes tube(s) or catheter(s); aggressive</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent non-purposeful movement, fights ventilator</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
<td>Anxious but movements not aggressive vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
<td>Not fully alert, but has sustained awakening</td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
<td>(eye-opening/eye contact) to voice (&gt;10 seconds)</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation</td>
<td>Briefly awakens with eye contact to voice (&lt;10 seconds)</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation</td>
<td>Movement or eye opening to voice (but no eye contact)</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation</td>
<td>No response to voice, but movement or eye opening to physical stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unarousable</td>
<td>No response to voice or physical stimulation</td>
</tr>
</tbody>
</table>

Procedure for RASS Assessment

1. **Observe patient**
   a. Patient is alert, restless, or agitated. (score 0 to +4)
2. **If not alert, state patient’s name and say to open eyes and look at speaker.**
   a. Patient awakens with sustained eye opening and eye contact. (score –1)
   b. Patient awakens with eye opening and eye contact, but not sustained. (score –2)
   c. Patient has any movement in response to voice but no eye contact. (score –3)
3. **When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.**
   a. Patient has any movement to physical stimulation. (score –4)
   b. Patient has no response to any stimulation. (score –5)

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


Step Two: Delirium Assessment

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
# CAM-ICU Worksheet

## Feature 1: Acute Onset or Fluctuating Course
**Positive** if you answer ‘yes’ to either 1A or 1B.

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

1A: Is the pt different than his/her baseline mental status? 
Or

1B: Has the patient had any fluctuation in mental status in the past 24 hours as evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment?

## Feature 2: Inattention
**Positive** if either score for 2A or 2B is less than 8.

Attempt the 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, then perform the ASE Pictures. If you perform both tests, use the ASE Pictures’ results to score the Feature.

2A: ASE Letters: record score (enter NT for not tested)

**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.”

Score (out of 10): ______

2B: ASE Pictures: record score (enter NT for not tested)

Directions are included on the picture packets.

Score (out of 10): ______

## Feature 3: Disorganized Thinking
**Positive** if the combined score is less than 4

3A: Yes/No Questions
(Use either Set A or Set B, alternate on consecutive days if necessary):

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

Score ___ (Patient earns 1 point for each correct answer out of 4)

3B: 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). *If pt is unable to move both arms, for the second part of the command ask patient “Add one more finger”*

Score ___ (Patient earns 1 point if able to successfully complete the entire command)

## Feature 4: Altered Level of Consciousness
**Positive** if the Actual RASS score is anything other than “0” (zero)

**Overall CAM-ICU** (Features 1 and 2 and either Feature 3 or 4):

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