Interior Health

Richmond Agitation Sedation Scale – Palliative Version (RASS-PAL)

Score	Term	Description
+4	Combative	Overtly combative, violent, immediate danger to staff, (e.g., throwing items): +/- attempting to get out of bed or chair
+3	Very Agitated	Pulls or removes lines (e.g. IV/SC/Oxygen tubing) or catheter(s); aggressive, +/- attempting to get out of bed or chair
+2	Agitated	Frequent non-purposeful movement, +/- attempting to get out of bed or chair
+1	Restless	Occasional non-purposeful movement, but movements are not aggressive or vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert but has sustained awakening (eye-opening/eye contact) to voice for 10 seconds or longer.
-2	Light Sedation	Briefly awakens with eye contact to voice for less than 10 seconds
-3	Moderate Sedation *(common goal)*	Any movement (eye of body) or eye opening to voice, but no eye contact
-4	Deep Sedation	No response to voice but any movement (eye or body) or eye opening to stimulation by light touch
-5	Not rousable	No response to voice or stimulation by light touch

Tool Notes

- The Richmond Agitation-Sedation Scale – Palliative Version (RASS-PAL) is a valid and reliable assessment tool to assess the person's level of sedation during Palliative Sedation Therapy (PST)[i].
- Unlike the original RASS, the RASS-PAL does not require eliciting a response using painful or startling stimuli;
- The aim of palliative sedation is to provide symptom relief with the lightest possible level of sedation necessary and/or as per the identified goals.
- Use of a standardized tool to assess level of sedation improves monitoring, communication and documentation in PST, see procedure on reverse.

Score	Procedure for RASS-PAL
0 to +4	1. Observe patient for **20 seconds** a. Patient is alert, restless or agitated **for more than 10 seconds**. Note if the patient is alert, restless or agitated for less than 10 seconds and is otherwise drowsy, then score patient according to your assessment for the majority of the observation period.
-1 -2 -3	2. If not alert, greet patient, call by name and say "open your eyes and look at me". a. Patient awakens with sustained eye opening and eye contact **(10 seconds or longer)**. b. Patient awakens with eye opening and eye contact, but not sustained **(less than 10 seconds)**. c. Patient has any eye or body movement in response to voice but no eye contact
-4 -5	3. When no response to verbal stimulation, physically stimulate patient by *light* touch, e.g., *gently* shake shoulder a. Patient has any eye or body movement to gentle physical stimulation b. Patient has no response to any stimulation

[i] Bush SH, Grassau, PA, Yarmo MN, Zhang T, Xinkie SJ, Pereira JL (2014). *The Richmond Agitation-Sedation Scale modified for palliative care inpatients (RASS-PAL): a pilot study exploring validity and feasibility in clinical practice.* BMC Palliative Care,13:17 1186/1472-684X-13-17.

Adapted for clinical use in Interior Health with written permission of Dr. Shirley Bush, original author, February 2020.