Supplemental Table 1 Method of the Richmond Agitation Sedation Scale assessment

Scale	Term	Description
+4	Combative	Overtly combative or violent; immediate danger to staff
+3	Very agitation	Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff
+2	Agitated	Frequent non-purposeful movement or patient–ventilator dyssynchrony
+1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact, to voice
-2	Light sedation	Briefly (less than 10 seconds) awakens with eye contact to voice
-3	Moderate sedation	Any movement (but no eye contact) to voice
-4	Deep sedation	No response to voice, but any movement to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

Evaluation procedure:

First. Is Patient restless or agitated (scale +1 to +4 using the criteria listed above)?

Second. Is patient alert and calm (scale 0)?

Third. If patient is not alert, in a loud speaking voice state patient's name and say to open eyes and look at speaker.

a. Patient awakens with sustained eye opening and eye contact (scale -1).
b. Patient awakens with eye opening and eye contact, but not sustained for 10 seconds (scale -2).
c. Patient has any movement in response to voice, but not eye contact (scale -3).

Fourth. If patient does not respond to voice, physically stimulate patient by shaking shoulder and/or rubbing sternum.

d. Patient has any movement to physical stimulation (scale -4).

e. Patient has no response to any stimulation (scale -5).

This procedure is referred to: Sessler CN, Gosnell MS, Grap MJ, et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care unit patients. Am J Respir Crit Care Med 2002;166:1338-44