Frequently Asked Questions and Answers
(65G-8) Reactive Strategies: APD Seclusion and Restraint Rule
v. 6/27/11

1. 65G-8.002 Does the requirement to train staff in a manual restraint curriculum apply to every provider and facility (e.g. including companions, SL coaches, PCA's, single owner "Mom & Pop" foster homes, etc.) or does this only apply to those providers who serve people whose behavior might require the use of manual restraint?
   The requirement to train staff in an emergency procedure curriculum applies to all facilities and providers that use reactive strategies with their clients.

2. 65G-8.002 Does this [rule] apply to public and private ICF/DDs?
   Yes, this rule applies to both public and private ICF/DDs. **See Ch. 393, F.S. DEVELOPMENTAL DISABILITIES,** specifically subsection 393.13(4)(h)2 CLIENT RIGHTS, "The agency shall adopt by rule standards and procedures relating to the use of restraint and seclusion [i.e., 65G-8 Reactive Strategies]". **AND** Ch. 400, F.S. **NURSING HOMES AND RELATED HEALTH CARE FACILITIES, PART VIII INTERMEDIATE CARE FACILITIES FOR DEVELOPMENTALLY DISABLED PERSONS**, 400.960 Definitions, (5) "Client" means any person determined by the Agency for Persons with Disabilities to be eligible for developmental services; (6) "Developmental disability" has the same meaning as in s. 393.063; (8) "Intermediate care facility for the developmentally disabled" means a residential facility licensed and certified in accordance with state law, and certified by the Federal Government, pursuant to the Social Security Act, as a provider of Medicaid services to persons with developmental disabilities. **ALSO**, within **Ch. 65G-8, REACTIVE STRATEGIES**, **65G-8.001 Definitions.** (6) "Client" means any person with a developmental disability receiving services in the State of Florida.

3. 65G-8 Is it correct that providers are expected to begin implementing this [rule] now (except for those provisions which have a grace period)?
   Yes, as of August 1st, 2010 all rule chapters were in effect and needed to be implemented, as is. Previously, there had been a grace period for 65G-8.002, 65G-8.003, and 65G-8.004 to ensure that available curricula were reviewed and approved by the Agency, and to allow providers sufficient time to address the rule requirements, including training of staff and development of internal policies consistent with these rules.

4. 65G-8.001 Is the critical difference between "time out" and "seclusion" the fact that it is **written into a behavior plan** or that it is a **consequence that is implemented consistently** for a specific behavior? For example, if removing a person to a separate room or area is written into a behavior plan as an **emergency procedure** to be used only when other procedures (e.g. redirection, prompting alternative response, blocking, etc.) are ineffective and the behavior presents an immediate danger, is this considered "time out" or "seclusion"?
   The use of an isolation procedure without a written behavior plan approved by the LRC is considered seclusion, and all applications are to be reported. In addition, use of "time-out" applications for periods greater than 20 minutes are considered seclusion (even if written in an LRC approved behavior plan), and must be reported.

5. 65G-8.002 For submission of the emergency procedure curricula:
   a) Will the Central Office be contacting major companies (e.g. PCM, CPI, Mandt, etc.) and requesting they apply for approval statewide, or should each APD provider/facility request approval individually for whatever system they use? For example, if a provider uses PCM as their crisis management system, does this mean that the Central office has contacted PCMA to submit the required information for approval so that providers can use PCM statewide? Is it the provider's responsibility to have PCM authorized or is it PCMA's responsibility?
      The Central Office has sent notice to a wide variety of vendors of emergency procedure/reactive strategy curricula. Thus far we have been contacted by or received materials from Professional Crisis Management (PCM), Alternatives for Behavioral Crises

(ABC), Facing Emergencies And Reacting, Crisis Intervention Training, Safe Crisis Management (SCM), Crisis Prevention Institute (CPI), Techniques for Effective Aggression Management (TEAM) and Mandt. There is an "Emergency Procedure Training Curriculum Review Tracking" link on the APD website that will be updated as reviews and approvals are completed.

These materials have not been reviewed and approved, yet. The time frame for this review is prior to the end of the "grace period", extended to Feb. 1st, 2010. Once reviewed and approved a list of approved curricula will be posted on the APD website. In most cases, the providers will not need to submit materials for review. In those cases where a "home-grown" or less commonly used curriculum is in place, the provider will need to submit materials for review.

b) If it is the provider's responsibility, what should they do if the company they use does not allow them to copy its materials without permission?
For a curriculum to be approved, a full set of training materials, including photos or videos of procedures or moves must be submitted to enable a review and disposition as approved or not approved. If the author or training vendor will not submit their materials they cannot be reviewed and approved for use under 65G-8.

c) If crisis management system companies are submitting applications to the Central Office directly, how can a provider determine if the system they use has already been submitted and/or approved?
A tracking tool will be created and posted on the APD website identifying which curricula have been received and what their status is in the review and approval process.

d) Approximately how long will approval take?
No history yet to comment.

e) If each provider needs to submit individually, will the Area offices have copies of the "Emergency Procedure Training Curriculum Application" form or will it be posted on the APD website, or should each individual provider/facility contact the Central Office themselves?
The "Emergency Procedure Training Curriculum Application" form will be posted on the APD website and can be obtained by calling the local APD Area Office or APD Central Office.

f) [Does each provider need to notify the Area Office or Central Office of which curriculum they are using?]
The notification of the local Area Office indicating which curriculum they are using is being considered as an amendment to the current rule.

6. 65G-8.002 Some agencies have written Emergency Procedure Curricula for their facility. Can an agency submit such a curriculum for review and approval by APD or must they adopt one of the approved commercial curricula?
An agency with a "home-grown" emergency procedure curriculum can submit materials for review. A full set of training materials, including training manuals, photos or videos of procedures or moves must be submitted with the a completed "Training Curriculum Review Application" identifying specifically where the required elements of the curriculum can be found amongst the materials.

7. 65G-8.003 Does the consent for use of reactive strategies need to be updated annually?
There is no requirement in this rule for updating consent annually, but should there be any changes to competency or guardianship, then it would be prudent to update.

8. 65G-8.002 The new rules state that training certification is valid for one year. Some systems have a two year approval. Will this now need to be annual? With PCM, it is one year, with an extra grace period of 3 months for staff and 6 months for instructors. Is this acceptable?
   This is an area where we will take suggestions from participants during an upcoming Workshop to look at amendments to language in the rule. A workshop was held on October 24th, 2008, another one needs to be scheduled to review revisions.

9. 65G-8.002 Can the 12 direct hours of training include the time spent doing the competency-based evaluation and written test?
   This is an area where we will take suggestions from participants during an upcoming Workshop to look at amendments to language in the rule. A workshop was held on October 24th, 2008, another one needs to be scheduled to review revisions.

10. 65G-8.002 Does the twelve direct training hours apply just to the initial emergency procedure training curriculum or also to the annual recertification? Some systems have a shorter training for annual recertification than they do for the initial time a person is certified. Must this recertification now be 12 hours?
    This is an area where we will take suggestions from participants during an upcoming Workshop to look at amendments to language in the rule. A workshop was held on October 24th, 2008, another one needs to be scheduled to review revisions.

11. 65G-8.004 Must the initial assessment be completed before admission to the facility? If not, how long after the admission does the provider have to complete the assessment?
    This can be an issue for the amendment workshop. The rule says, "Upon an individual's admission". My opinion: Ideally, it should occur before admission, or as part of a transfer packet, especially where there is a history, but at least within the first 30 days of admission, consistent with other assessments and planning.

12. 65G-8.004 Some providers (e.g. ADT's) serve a mix of people, many of whom do not display problem behavior. Must the initial assessment be done on everyone in the facility or only those for whom reactive strategies might reasonably be expected to be used?
    This can be an issue for the amendment workshop. It might be useful to have "something" on everyone, at least to say that the person has no history of significant maladaptive behaviors that have necessitated the use of reactive strategies in the past 12 months. (Ref: Core Assurances for all Med Waiver Providers, including WSCs).

13. 65G-8.004 Does the requirement for an annual assessment apply to ADT's? Since they are not involved in physician's visits (especially for people living in family homes), how will they share the information on reactive strategies and get the physician's part of the assessment done?
    This can be an issue for the amendment workshop. This has come up multiple times on different issues, but it's apparent that the communication between residential providers and ADTs is not all that it could be. If the person has exhibited behaviors warranting the use of reactive strategies in their place of residence, an assessment should have been done, and should be shared with other providers. If this is not the case, the ADT should not apply reactive strategies without an assessment. Who then is responsible? The ADT, like the residential provider can accept or reject a client at will, and will be liable if something goes awry during the use of a reactive strategy if

reasonable and necessary precautions were not taken. (Ref: Core Assurances for all Med Waiver Providers, including WSCs).

14. 65G-8.004 Is there any specific format or information that needs to be included in the physician's report for the initial assessment? Will there be a specific form?
The rule says, "*A physician's report of medical conditions or physical limitations that would place him or her at risk of physical injury during restraint or seclusion, or otherwise preclude the use of one or more reactive strategies*".
Also, there is a list of medical conditions or physical limitations that should be considered as adding risk to some reactive strategies. A draft of a model document that could be used to obtain the needed information is available from APD, but the use of a specific form is not a requirement of the rule.

15. 65G-8.004 Who is responsible for asking the physician to write the physician's report?
Either existent reports of physical condition or at the time of a visit for physical exam, the doctor may complete the form presented by the provider staff, or notes may be entered on the form by staff at the time documenting any health and safety risks or any emergency procedures that would be contraindicated.

16. 65G-8.004 Whose responsibility is it to shrink or summarize the reactive strategies curriculum and to show the procedures to the physician so s/he can see what they entail?
The providers or provider's designee will need to assume responsibility for providing the physician with the necessary information regarding procedures a client may be subject to in order for the doctor to identify medical risks or limitations and provide the needed medical clearance.

17. 65G-8.004 Is the physician also the person responsible for evaluating the information regarding previous trauma, history of sexual abuse, etc.? If so, whose responsibility is it to share this with the physician?
There is no requirement for the physician to do this. In other human services organizations this is completed by social workers, nursing staff, or other team members as assigned by the provider agency.

18. 65G-8.004 If a physician is unwilling to sign a release statement regarding risk, how should this be handled? Is an actual release signed by the physician required, or is a statement from the physician of the risks and any contraindications sufficient?
If the physician is unwilling to sign a release statement regarding risk, staff present at the time of the visit may document any health and safety risks or any emergency procedures that would be contraindicated, based upon statement by the physician.

19. 65G-8.004 What is the difference between conditions that create a <u>risk</u> of injury with seclusion/restraint, and conditions that <u>preclude</u> the use of seclusion/restraint?
In context, "*Medical conditions or physical limitations that might create a risk*", means there are conditions that need particular scrutiny. For example, in the case of "obesity" some of the deaths attributable to prone restraint occurred with obese individuals who could not get sufficient oxygen, or had heart attacks. This doesn't mean all obese people can't be restrained. It simply means prone may not be a good approach in those cases where the individual already has reduced respiratory capacity. In context, "*preclude the use of one or more reactive strategies*", means that there may be some procedures that should be ruled out or prohibited from use with an individual with a known risk.

20. 65G-8.004 If the physician says a person has a risk factor but says that restraint may still be used, what additional safeguards or procedures should the provider employ?
    It would probably depend on the specifics of the risk, but consideration should be given to that risk and see if there are some alternative strategies or techniques that will avoid the risk or at least not exacerbate it.

21. 65G-8.004 If a person has an initial assessment at one facility and then transfers to another program in less than a year, is this assessment "transferable"? Can the new provider use the assessment from the old provider until it "expires" at the end of a year?
    Currently, there is nothing to say that you can't do this, as long as you are comfortable that what another provider reported is accurate, is still current, and is available in the person's record. Otherwise, it would seem that the most practical life-cycle of the assessment, or "end of a year" would be the anniversary of the Support Plan.

22. 65G-8.002 It appears that in order to authorize the use of seclusion, the authorizing agent must, among other things, be certified in an Agency-approved reactive strategies curriculum.
    a) Does this mean that if a facility/provider does not use or train staff to use manual restraint, they cannot use seclusion?

    Unless the person(s) requiring seclusion is (are) compliant enough to respond to verbal prompts or shadowing, it's hard to imagine getting someone to seclusion without a "hands on" technique. Otherwise, that is correct, staff must be trained in those procedures that are used within the facility.

    b) Could a provider develop and have approved a reactive strategies curriculum that does not include manual restraint?

    If the provider intends not to touch any client in a behavioral emergency or crisis, then it would appear that they are not using reactive strategies, and do not need an approved curriculum. However, uses of emergency medication, Baker Act, or Law Enforcement are considered reactive strategies for the purposes of reportable events. In turn, should individuals receiving services need reactive strategies more than twice in 30 days or six times in a 12-month period the development of a behavior plan is required (65G-8.006 - Limitations on Use and Duration of Reactive Strategies).

23. 65G-8.005 Since reactive strategies are used in crisis situations, it may be difficult to get authorization at the time they are initiated. Is it permissible for staff to get the situation under control first and then call for authorization, notify the highest-level direct supervisor of use, etc.?
    Yes, in particular, during some parts of the day this may be the best that one can do. On the other hand, for staff and client safety, consideration for some means of communication should be given to enable staff to alert someone that there is an emergency, e.g., radio, intercom, "panic button". Otherwise, a staff person should not be left alone in those circumstances where it is likely that a two-person reactive strategy is needed.

24. 65G-8.003 & 65G-8.005 Seclusion and restraint may not exceed 2 hours without visual review and approval of the procedure by an authorizing agent **or the agent's on-site designee**. a) How is this person designated? b) What are the qualifications of the designee? c) For example, if staff call for authorization of seclusion or restraint, when the authorizing agent calls back can he or she authorize someone to act as a designee (in case the procedure exceeds 2 hours) and then not come on-site?
    a) Each residential provider will need to develop policy and procedure to address ***65G-8.003 Reactive Strategy Policy and Procedures*** as an initial step toward making these assignments;
    b) The authorizing agent's qualifications are identified in ***65G-8.005*** *(3)(c)* ***Authorizations for Specific Reactive Strategies.***
    c) If an "on-site" designee is used, this person's qualifications should match as closely as possible those of the original authorizing agent. At the very least this person should be certified in the procedures being used, and have the authority to stop a procedure, if necessary.

25. 65G-8.001 If a person is currently using behavioral protective equipment or mechanical restraints as part of an LRC-approved behavior plan rather than as a reactive strategy, must the use of this equipment be reauthorized every hour as with a reactive strategy? (For example, person moves into group home and wears a helmet or arm splints. A plan is in place to gradually fade these out, but currently the person wears them 24-7.)
    No, restraint equipment used as part of a LRC-approved behavior plan, or as behavioral protective device, does not require hourly re-authorization. However, the use of the equipment must be documented and reported on the Reactive Strategies Report.

26. 65G-8.001 If protective equipment is used for an individual and is NOT part of an LRC approved behavior plan (i.e. physician has written an order for protective helmet), does the use of this equipment fall under the criteria for mechanical restraint?
    Unless the doctor's order is for use of restraint as a "medical protective device" while the person is recovering from a medical condition, then the equipment is being used as mechanical restraint, and needs to be reported as such.

27. 65G-8.007 If protective equipment is used as part of an LRC approved behavior plan, what are the requirements for use, monitoring and opportunity for motion and exercise? The same as mechanical restraint?
    The requirements for protective equipment used as part of an LRC approved behavior plan are the same as those for mechanical restraint, including reporting.

28. 65G-8.005 The authorizing agent for behavioral protective devices and mechanical restraint includes behavior analysts certified by the Agency pursuant to 65G-4.003. Does this include all FL CBA's or only those who would meet the criteria for expanded privileges (e.g. Master's degree, etc.)?
    Currently, the rule allows all persons with active certification as BCBAs by the Behavior Analyst Certification Board®, Inc. (BACB); and FL CBAs with active certification by the Agency pursuant to Section 393.17, F.S., and by Rule 65G-4.003, F.A.C. to serve as an authorizing agent for behavioral protective devices and mechanical restraint.

    At this point in time the BACB has permitted those CBAs who had the required education and experience to transfer over to their equivalent BACB certification. There are no longer any FL

CABAs. They either transferred to the BACB or let their credentials lapse. There continue to be about 150 FL CBAs (with full privileges).

29. 65G-8.008 For the use of chemical restraint, must the authorizing agent (the physician) be contacted every time it is used?
    Yes, the authorizing agent (the physician, *licensed under Chapter 458 or 459, F.S*) must be contacted every time chemical restraint is used.

30. 65G-8.008 For chemical restraint, is it acceptable to have a "PRN" order from the physician for use of a medication that says when it should be used? If not, would it be acceptable to have a standing order, already have the prescription filled, and then just call the physician for authorization to use it?
    Use of any reactive strategy on a "PRN" or "as required" basis is prohibited. However, it would be acceptable to have a standing order, already have the prescription filled, and then call the physician for authorization to use it. The intent is to assure that an appropriately licensed person determines that the procedure is indeed the *least restrictive, most appropriate alternative available* and then determines the conditions of administration and follow-up. Keep in mind that, *if the authorizing physician is not present to write the order, he or she must dictate the order's contents to another on-site licensed medical professiona*l.

31. 65G-8.008 If a person has a prescription for medication to be used "PRN" when the person feels "agitated" and requests it (i.e. client initiates it, not staff), is this still considered chemical restraint according to this rule?
    An individual may receive a "PRN" medication under this rule, if it is self-initiated. Otherwise, administration must comply with *Chapter 65G-7: MEDICATION ADMINISTRATION*.

32. 65G-8.009 It states under "Prohibited Procedures" that movement of body parts is prohibited. Many crisis management systems utilize movement in order to get the person's body in the right position for the procedure or to transport/escort the person to another location. Is this permissible? What kinds of movement of body parts are prohibited?
    This is an example of a content area where an amendment to the rule will be needed to clarify the language. Clearly, there may be some movement of body parts, but those that result in the *hyperextension or twisting of body parts* are prohibited.

33. 65G-8.009 Under "Prohibited Procedures" it states that documentation of vital signs must be completed for containment. Which vital signs are required? What kind of documentation is required and how often?
    Under **65G-8.009 Prohibited Procedures** it states that *containment without continuous monitoring and documentation of vital signs and status with respect to release criteria* is prohibited. At minimum this would mean that, *Staff must continuously observe the client during* the containment *procedures, monitor respiration rate, and determine when release criteria have been met*. With regard to documentation, you will note that in the case of chemical restraint, that *at least once every half-hour* is the minimum, nursing practice would probably recommend every 15 minutes. In recording the person's status, as it relates to release criteria, a minute-to-minute recording would be ideal, as most release criteria are based on a specified number of minutes of calm and quiet or non-agitated behavior, and staff are there anyway to monitor continuously. Monitoring of respiration is probably the simplest and will allow counts and recording of condition without being intrusive.

34. 65G-8.009 Under "Prohibited Procedures" it states that using reactive strategies on a PRN or as required basis is prohibited. How is "PRN" defined? Can a behavior analyst state in the behavior plan when a reactive strategy should occur? Can reactive strategies be used in an emergency (i.e. since this is essentially PRN or when needed to keep a person or others safe)?
    All occurrences of maladaptive behavior are not equal, it may be that an individual can be redirected or given a warning before going directly into restraint, but this should be an individualized planning decision. On the other hand, a standard 2 hour application of restraint for all individuals is not appropriate, either. Therefore, criteria for release should be based upon the person's calm behavior, which is under their control. Even here, "calm criteria" may need to be individualized as some folks require a shorter or longer period of calm.

35. 65G-8.010 a. When should the Reactive Strategy Report be filled out? b. Is it whenever a listed procedure is used regardless of the consumer having a Behavior Plan or not? c. Which providers fill out the Report (e.g. Companions, PCAs, CBAs, ResHab, ADT, etc.) or is it only for specific providers?
    a. If the Reactive Strategy Report is your primary means of recording these procedures, then all uses of reactive strategies or "reportable events" should be entered at the time of an event requiring a reactive strategy. Some providers may choose to use another "working document" for the ease of staff recording and then enter the information electronically into the Excel-based report daily, weekly or at the end of the month for submission to the Area Office.
    b. Reactive strategies should be entered into the Reactive Strategy Report whether there is a Behavior Plan or not.
    c. All uses of reactive strategies should be reported, regardless of who the provider is. Keep in mind that this is at least one data source for determining whether formalized behavioral procedures are needed and whether they are effective or not.

36. 65G-8.010 Are facilities required to maintain any documentation that demonstrates that the following occurred during use of each reactive strategy procedure: 1)continuous monitoring occurred, 2)vital signs were taken as indicated according to rule, 3)opportunity for motion and exercise provided if restraint exceeded one hour, 4)documentation of authorization of and 5)reauthorization of procedure?
    In section **65G-8.010 Documentation and Notification** requires that:
    (1) Staff must document the following information in the individual's record as soon as possible, but no later than the end of the work shift following the use of a reactive strategy:
        (a) The behavior that necessitated a reactive strategy;
        (b) The reactive strategy used;
        (c) The date and time the reactive strategy was implemented and the time the strategy was terminated; and,
        (d) The person(s) who initiated, applied, authorized, and terminated the reactive strategy;
    (2) The authorizing agent must review and sign the reactive strategy documentation within twenty-four hours or by the end of the next business day.
    (3) The service provider or facility must also document every use of a reactive strategy on the "Reactive Strategy Report
    A work document could probably be created that includes all of the required items and the remainder identified in the question above. If minute-by-minute recording is contained on the work document, that would pretty much show "continuous monitoring". Plus, all the other items could go on the same sheet and be placed in the client's record, without requiring another note.

37. 65G-8.001 Is medication prescribed by a physician to be given for sedation prior to a medical procedure considered chemical restraint?
    Medication prescribed by a physician to be given for sedation prior to a medical procedure would not be considered chemical restraint, and does not require reporting on the Reactive Strategy Report.

38. 65G-8.010 On the reactive strategies reporting form, there is no choice for "ICF" (other than state DSI's) in the dropdown box under "Type of Facility". Should ICF's use "Other"?
    For now, use "Other". This was an oversight and will be added as soon as possible.

39. 65G-8.010 On the reactive strategies reporting form, what is the difference between "Chemical Restraint" and "Stat Meds"? If a medication is already prescribed and is given at a different time or dose than usual on a physician's orders for the purpose of behavioral control, wouldn't this still be chemical restraint? If it is given at a different time/dose for some other reason, wouldn't this be a medication change (if there was a physician's order) or a medication error (if no physician's order)?
    Chemical restraint is the use of medication to affect the immediate control of the person's behavior if that medication is not one that is part of the individual's usual medication regimen. Stat medication means administration of medications that are prescribed routinely but given at a different time or a different dose than the person usually receives (including PRN meds) to get immediate control of a person's behavior.

    Medication change on the reporting form is intended to indicate if the person has had a change in their regular medication regimen in the past 30 days, preceding this event that required another reactive strategy.

    Please note that you can "click" on the column titles on the electronic form to view a comment showing the definition of that reporting element.

40. 65G-8.001 If a person goes into time out (per the behavior plan) and it lasts for 25 minutes, it is then seclusion since it is longer than 20 minutes. Is the total duration of seclusion reported as 25 minutes or 5 minutes?
    Use of time-out exceeding 20 minutes constitutes seclusion for reporting purposes and the total period of time the procedure is used must be recorded. While a work document may be used by staff to record use of time-out, those occurrences exceeding 20 minutes must be submitted on the Reactive Strategies Report as Seclusion, and submitted to the APD Area Office monthly. In the example provided, seclusion would be recorded for the 25 minute duration. The rule is not asking providers to report time-out used for 20 minutes or less on the Reactive Strategies Report, but it should be recorded and become part of the client's record for behavior management purposes.

41. 65G-8.008 For how long must staff record the effects of chemical restraint?
    In the case of chemical restraint, while documentation is required *at least once every half-hour*, nursing practice would probably recommend every 15 minutes until the desired effects of the medication have been achieved, or the on-site medical professional determines that no further monitoring is required.

42. 65G-8.007 What does "monitor respiration rate" mean? Are direct care staff supposed to measure respiration or just observe respiration patterns? The term "rate" has a measurement connotation.
The variables identified below can be used to monitor (and record) respiration. They can be used to fashion a simple checklist, determine a single rate, or can be used in combination.

Respiration or the effectiveness with which a person can breathe can be monitored by rate and depth, as well as other characteristics that can enable staff to evaluate an individual's condition. The normal range of respiration in an adult at rest is 12 to 20 breaths per minute (BPM).

Normal respiration results in what would be described as deep and even (movement in the chest). If respiration is deep, the rib cage expands fully. If respiration is shallow, the rib cage does not expand to its normal size.

If respiration rate is above the normal range (>20 BPM), it is described as rapid. If respiration rate is below the normal range (<12 BPM), it is described as slow.

A pattern of sustained rapid, deep respiration is called hyperventilation. If respiration is shallow and rapid it is described as being short of breath.

Abnormal respiration may be characterized by an irregular breathing pattern, it may be labored or require effort. Difficult breathing may be accompanied by pain or noises (wheezing, rattling, bubbling, coughing, etc.). A person having difficulty breathing may lean forward with their arms braced against their knees, or they may appear anxious or restless. A person with breathing difficulty may appear pale, ashen (gray), or cyanotic (blue) in the face and lips.