ECG interpretation

Assessment of competences for ANP/ACP/SCP

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please note: Practitioners can add DOPS, PBAs and CEXs as evidence.**

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|  | | **NOT competent** | **Competent** | **Signature and date** |
| ECG interpretation | | | | |
| 1 | Different types   * Rhythm strip * 12 lead ECG * Continuous monitoring |  |  |  |
| 2 | Indications   * Benchmark * Pre op * Post op * Underlying pacing * Patient unwell? cause * Dysrhythmia |  |  |  |
| 3 | Physiology   * Conduction system * Cardiac cycle * P wave – atrial depolarisation * QRS – ventricular depolarisation * T – repolarisation |  |  |  |
| 4 | Analysis   * Annotation * Calibration 10 mm = 1 mV. Paper speed = 25 mm/s = 25 small squares = 5 large squares = 1 sec * 1 large square = 200 ms, 1 small square = 0.4 ms * Correct recording, quality, limb placement |  |  |  |
| 5 | Rhythm strip analysis   * Clinical review of patient and CVS * Rhythm * Rate * P wave height <2.5 mm. Length <0.08 ms * QRS duration <120 ms * PR interval 120–200 ms * QT interval >380 <420 mm BUT r/v rate and sex |  |  |  |
| 6 | Abnormal rhythms   * Asystole * VT (with pulse or pulseless) * VF * PEA * Sinus tachycardia * Atrial fibrillation * Atrial flutter * Sinus bradycardia * Junctional * Heart block |  |  |  |
| 7 | Heart blocks   * 1 degree HB PR >200 ms * 2 degree HB type I (Wenckebach) – PR lengthening and dropped QRS * 2 degree HB type II – PR constant, frequent dropping of QRS * 3 degree HB no associated P/QRS activity |  |  |  |
| 8 | 12 lead ECG analysis   * Axis * Exclude bundle branch block * Limb leads * Chest leads * Territories relate to CAs * Q wave – deeper than 0.2 mV +/or wider than 40 ms * QRS – S wave in V1 + height of R wave in V6 <35 mm. Width <120 ms * LBBB and RBBB * ST segment * T waves * S1Q3T3 – PE |  |  |  |
| 9 | Atrial ECG   * Indications ? Atrial activity/AF/flutter |  |  |  |
| 10 | How to perform   * Baseline 12 lead ECG * Take Rt arm limb lead or V1 and attach to the atrial pacing wire * Atrial activity will be amplified and can be compared with the routine ECG |  |  |  |
| **Assessor’s comments** – Demonstrates that the practitioner has ordered the CXR appropriately in accordance with postoperative protocol or based on abnormal clinical findings.  Demonstrates that the practitioner has review the CXR in a systematic way, and ensures they have identified the correct legal and clinical aspects.  The practitioner comments on the findings in relation to previous CXRs.  The practitioner is able to verbalise the correct course of action that should be taken if there are any abnormal findings, to include communication with the multidisciplinary team and the documentation according to the practitioner’s professional body and code of conduct: | | | | |
|  | | | | |
| **This practitioner has completed these outcomes to the appropriate standard.**  **Assessor’s name:**  **Signature and date:** | | **Practitioner’s signature:**  **Date:** | | |