Interview coding matrices (**2.0** ECG waveform)

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|  | **2.0** ECG waveform | | | | | | |
| **2.1** P-wave | **2.2** QRS complex | **2.3** ST-segment | **2.4** T-wave | **2.5** Axis | **2.6** Rhythm strip | **2.7** Baseline |
| P2F | I’ve been taught to look at the P waves... | I’ve been taught to look at the P waves, QRS complex etc |  |  |  | I feel I spent quite a lot of my time looking at the bottom lead.  I find I automatically look at the leads I know, being the bottom lead. . . |  |
| P5M | I start with looking at the chest leads and the P waves.  I look at P waves preceding the QRS complex, make note of any kind of deviation.  Is a P wave preceding it? | I look at P waves preceding the QRS complex, make note of any kind of deviation.  I think the main area of importance is the rate, with QRS complex analysis coming at the end. |  |  |  | Slowly I work my way down to lead II at the bottom, looking at the rhythm strip for rate. |  |
| P6F | I start with the P waves |  | I start with the P waves, then examine the rhythm and look for ST changes. |  |  |  |  |
| P9M |  | I’m quite dependent on marking regularity on the paper, same with the QRS complex |  |  |  |  |  |
| P10F | I know P waves can be hiding, or inverting halfway through etc. |  |  |  |  | Then I look at rhythm strip to get a bigger picture and identify abnormalities. | Some of them needed a better rhythm strip for more info, as the baselines were a bit funny on some. |
| P11F |  |  |  |  |  |  |  |
| P13M |  |  |  |  |  |  |  |
| P16F | I try to look at the P waves first. . . | . . .then the QRS complex |  |  |  |  | Now we give people a copy of their ECGs so they know it’s their normal ECG |
| P18F |  |  |  |  |  |  |  |
| P19F |  |  |  |  |  |  |  |
| P20F |  |  |  |  |  |  |  |
| P21M | I was taught to break it down into P waves, | QRS complexes | and to look at the ST segment | and T waves | and axis analysis |  |  |
| P23F | see if it’s regular and if I can see P waves. |  |  |  |  |  |  |
| P24M | I was trying to look for P waves and things and couldn’t always see everything that I wanted to.  are P waves present, what’s their relationship to the QRS complex | are P waves present, what’s their relationship to the QRS complex  and then I look at the chest leads for morphology of the QRS complex and T waves. |  | and then I look at the chest leads for morphology of the QRS complex and T waves. | then occasionally I look at the cardiac axis although that’s generally not very useful for rhythm interpretation | I’d always want an ECG with a rhythm strip. |  |
| P25F | what’s your P wave – is it tall, wide? | What’s your QRS like, is it notched or something like that? |  |  |  |  |  |
| P26F | I start off with the P waves and the QRS complexes but when you see AF, because I know there’s no P waves | The heart block you like to measure it out to see whether there’s association or dissociation with the QRS complexes.  Then I look at the shape of the QRS complex and how broad it is | Then I look at the shape of the QRS complex and how broad it is and ST segment. |  | Some senior people wouldn’t know how to look at axis on a quick analysis. |  |  |
| P27F | I check the seconds of P wave and PR interval to work out the rhythm. |  |  |  |  |  |  |
| P28F | because if you can’t see P waves and have an irregular rhythm you need to be able to see that baseline to determine what’s going on. |  |  |  |  |  | If you have a bad baseline. Some of the ones you’ve included have a wobbly baseline but you need to be able to see through that so it’s good you’ve got a few of them on there, because if you can’t see P waves and have an irregular rhythm you need to be able to see that baseline to determine what’s going on. That can be tricky. |
| P29F | The waveforms really, so if there’s sinus rhythm by looking at the P wave and QRS complexes and then if there’s anything abnormal. | The waveforms really, so if there’s sinus rhythm by looking at the P wave and QRS complexes and then if there’s anything abnormal. |  |  |  | I tend to always go for V1 first to see if there’s any bundle branch blocks and you can see the complexes clearly, and then I always go for the rhythm strip along the bottom which is usually lead II. |  |
| P30M | is there a P wave for every QRS complex | after that you’re looking at the QRS complex themselves | they see ST elevation and ST depression. |  | the axis if you wanted to know about the axis  and then I go and look at the axis and work from there. By the time I’ve done that I’ve looked at the axis and know what I’m looking at. |  | Also things like if one lead shows me a wandering baseline that’s a little bit irregular that looks like AF and the other leads don’t show that then you mustn’t just look at one lead – you need to be able to take the whole picture. |
| P31F |  |  |  |  |  | I know how I look at them now, I look straight at the rhythm strip. |  |
| P32M |  | see if there’s any prolonging of the QRS or ST elevation. |  |  |  |  |  |
| P33F |  | then you look at the intervals, the QRS duration and the QRS morphology and the ST segments  The conduction, the 1 to 1 relation of the QRS can be commonly mistaken. | then you look at the intervals, the QRS duration and the QRS morphology and the ST segments  ST changes can be commonly mistaken with hypertrophy. |  |  | I’d have liked to have a longer rhythm strip to look at. |  |
| P34M |  |  |  |  | In those ECGs you go through the main points but things like prolonged PR intervals, left axis deviation you tend to skip over and you just concentrate on the other more relevant stuff. |  |  |
| P36F | You need to be assessing what you’re rhythm is (as in have you got P waves)  you have to start with P waves, measure out intervals etc | have you got a QRS complex following every P wave to determine you’ve got normal conduction going down to your ventricles, are your QRS complexes normal (as in are they broad or narrow). |  |  |  | .It’s systematic really, and then you look at your rhythm strip to determine rate and arrhythmia |  |
| P37F |  |  |  |  |  |  |  |
| P38F | The first thing I look for is the P wave, then I look at rate and conduction and then the ventricular complexes. |  |  |  |  |  |  |
| P39F | We look at conduction defects, and the morphology. We look at each and every individual complex; QRS, P wave, ST segment, PR interval and T waves. | We look at conduction defects, and the morphology. We look at each and every individual complex; QRS, P wave, ST segment, PR interval and T waves. | We look at conduction defects, and the morphology. We look at each and every individual complex; QRS, P wave, ST segment, PR interval and T waves. | We look at conduction defects, and the morphology. We look at each and every individual complex; QRS, P wave, ST segment, PR interval and T waves.  A patient coming in with chest pain you’d expect ST changes, T wave inversion. |  |  |  |
| P40F |  |  |  |  |  |  |  |
| P41F | If there’s an R wave following a P wave, that’s how I was taught.  It depends, the more junior you are you just look at the ECG and don’t look for P waves whereas that’s generally the rule of thumb – look for P waves. I don’t think people always do this. And panic as well, which I did. That was horrible! People might panic and not look for the basis P wave, latch onto the first big thing they see. |  |  |  |  |  |  |
| P42F |  |  | then looking for any ischaemic changes (ST or T wave changes) | then looking for any ischaemic changes (ST or T wave changes) |  | Initially I start off looking at the whole thing and then I panic, and move to the rhythm strip. Not all of those had rhythm strips so it was a bit more difficult. |  |