Interview coding matrices (**4.0** Training and experience)

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|  | **4.0** Training and experience | | | |
| **4.1** Applying training to current situation | **4.2** Barrier to applying training | **4.3** Lacking experience | **4.4** Feeling that they have sufficient experience |
| P2F | I’ve been taught to look at the P waves, QRS complex etc  I’ve been taught to use a system but don’t really know it well enough to reply on. | I’ve been taught to use a system but don’t really know it well enough to reply on.  Being taught the system did help, but I find unless I’m regularly reading ECGs and have instruction I forget how to use the system and interpret them. | I’m not sure I’ve really had enough experience to make any significant errors.  - again, not really sure I’ve had enough experience reading ECGs to change my approach. |  |
| P5M |  |  |  | I’ve been working with ECGs for the past 3 to 4 years, so relatively solid experience. |
| P6F |  |  |  | I feel I should recognise most ECGs, have had 2.5yrs solid ECG training.  Fairly confident, I do a fair amount of teaching – overall a 4/5 for confidence. |
| P9M |  |  |  |  |
| P10F |  |  |  | Relatively experienced |
| P11F |  |  |  |  |
| P13M |  |  |  | I’ve had previous experience with ECGs but not much – more textbook learning. |
| P16F | Clear features are automatically recognised. That was the way we were taught anyway |  |  | It used to be absolutely fantastic but because of working in the cath lab I’m used to seeing the same ones over and over again (heart attacks, ischemia etc), acute conditions and WPW (electrical ones) and VT/VF – always see this. |
| P18F |  |  |  |  |
| P19F | I’ve been taught to look for the 5 dangerous rhythms – myocardial infarction, SVT, VT, atrial systole and 1 other…I can’t remember. |  |  |  |
| P20F |  |  |  | Relatively good, I’ve had 15 years experience. |
| P21M |  |  |  | I’ve been qualified as a cardiac physiologist for 3-4 years and have been doing ECG interpretation on a regular basis since so I’d say I’m very experienced. |
| P23F | Some things you can just pick up, like VT or VF, I’ve been trained to pick these up really quickly but I doubt a lot as well. |  |  |  |
| P24M |  |  |  | Reasonably fine, I do a lot of ECGs as a registrar. |
| P25F | Like Brugada syndrome, can be mistaken for an anterior myocardial infarction; it’s good to see these things whilst you’re training so you recognise them a bit more. |  |  | I’m a cardiac physiologist, so I should get them all right but there were a few I wasn’t too sure on. |
| P26F |  |  |  |  |
| P27F |  |  |  |  |
| P28F | Generally, I specialised in pacemakers so that’s what I do most of the time.  When you’re learning you’re very thorough, you start with each beat and you go along. You think you look at it overall. For certain rhythms you know to look at a certain lead or if you see something immediately, like myocardial infarction, your eye gets drawn immediately to that area. You know to look in certain areas for certain things. | Yes, sometimes I think I look too much into things. |  | It’s quite good, well…it should be. I’ve been doing the job for about 6 years, 2 years since qualifying. I’m a cardiac physiologist. |
| P29F | I think I’ve learnt one set way and stuck to that. |  |  |  |
| P30M |  |  |  | I’m a consultant cardiac physiologist and I teach ECG interpretation to doctors, nurses, undergraduate medical students so I think I have good, sound knowledge of fundamentals of ECGs – if you know the normal then in effect you can recognise any abnormalities. I’ve had 20 years experience overall. |
| P31F |  |  |  |  |
| P32M |  |  |  | Yes, definitely. I still try to be systematic but the more experienced you get the more you rely on pattern recognition. You’re still aware that you can miss things though so I try to go back and be systematic. If something strikes me as obvious in the first instance then I might just accept that or I might go back and have a closer look. |
| P33F |  |  |  |  |
| P34M |  |  |  | I would say that the more experienced you get you train yourself to only look at the important things. So when you first learn you go through a long protocol of breaking an ECG down bit by bit and then the more experienced you get the more you start looking for significant things. 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 | Yes, in your early days you have to be a lot more systematic in your approach, you have to start with P waves, measure out intervals etc and you need to spend a lot more time analysing them. |  | I think a lot of ECGs can be very complex, you can look at it (like an SVT) and not see things. It all comes down to experience and how frequently you’re used to looking at them. |  |
| P37F |  | Your first port of call is your ECG and it reflects back to everything you do in your job. If you go to somebody on the ward, maybe a nurse who’s been taught by another nurse but there’s no common training for them, they’ve just picked it up from someone else. | it depends on who’s doing the ECG. If they don’t get their position’s right then you can think there’s something on the ECG that isn’t there. The biggest thing that I noticed is that people think they can do ECGs but there’s no level of training there. |  |
| P38F | *Do you ever use a system?* Yes, that’s how we started our training and I still use that. |  |  | I’m a cardiac physiologist with 30 years experience. I feel pretty confident, there were 1 or 2 I’d have liked to have seen on paper. |
| P39F |  |  |  |  |
| P40F |  |  |  |  |
| P41F | If there’s an R wave following a P wave, that’s how I was taught. |  |  |  |
| P42F | I think when I was a medical student I didn’t really know what was going on, there was just so much to take in, whereas after working in A&E, if somebody comes in with chest pain then you’re more focus on finding those kind of changes on the ECG. You tailor it to clinical situation. |  |  |  |