**Rhythm Assessment Documentation Tool & Action Guidelines**

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| **Method Used** | * Telemetry. Indicate which Lead(s): \_\_\_\_\_\_\_\_\_ * 12/15 Lead ECG |  |
| **Heart Rate** | \_\_\_\_\_\_\_\_\_\_(Adult 60-100)  \_\_\_\_\_\_\_\_\_\_(Paed 1-10 years old 60-140)  \_\_\_\_\_\_\_\_\_\_(Infant to 1 year old 100-160) | Check patient. Inform M.D. if outside these parameters.  Inform M.D. STAT if patient is unstable. |
| **Regularity** | * Regular * Irregular. If irregular, document range: \_\_\_\_\_\_\_\_\_ | Inform M.D. if this is a change from previous rhythm recording. |
| **PR Intervals** | * PR interval is the same \_\_\_\_\_\_\_\_\_ (0.12-0.2 seconds) * PR interval is changing (consider AV Block) | If this is a new changing PR interval, check patient, do an ECG and Inform M.D. |
| **QRS** | \_\_\_\_\_\_\_\_\_ (no greater than 0.12 seconds) | If new wide QRS, check patient, do an ECG stat and Inform MD |
| **QT Interval**  **QTc (Corrected)** | \_\_\_\_\_\_\_\_\_(Less than 0.44 or Half the R-R).  \_\_\_\_\_\_\_\_\_(0.36-0.44 males, 0.36-0.46 females) | Note: QT Interval varies with Heart Rate.  Do ECG to determine QTc if: wide QRS, atrial fibrillation or bradycardia.  If prolonged QT from previous assessment, Inform MD. Check recent electrolytes and medication. |
| **ST Segment &**  **T Wave** | * Normal (isoelectric) * Elevated * Depressed * T wave depression | If anything but isoelectric, check patient, consider a STAT ECG and Inform the MD STAT. If patient is symptomatic, this is likely an ACS. |
| **Rhythm** | * Sinus rhythm with normal intervals * Sinus bradycardia * Sinus tachycardia * Sinus rhythm with a wide QRS (BBB morphology) * Paced rhythm * AV Block: What type:\_\_\_\_\_\_\_\_\_ * Atrial Fibrillation or Atrial Flutter * SVT: Circle rhythm if known - PSVT, Atrial Tachycardia, PAT, MAT, Atrial Flutter, Atrial Fibrillation, AVNRT, AVRT * Junctional rhythm * Ventricular rhythm (20-40) * Accelerated ventricular rhythm (40-100) * Ventricular tachycardia (>100) * Ventricular fibrillation * Asystole/Agonal | If any rhythm is new compared to the previous rhythm, assess patient’s VS and inform MD.  If unstable and slow: Consider atropine, pacing  If unstable and fast: If Sinus tachy: treat cause  If unstable and fast with pulse: Follow HSF Unstable Tachycardia algorithm  If no pulse: Start CPR call a Code |
| **Ectopy (abnormal)** | * Premature beats are present. If yes, circle if narrow or wide (PVC). * Escape beats/rhythms. If yes, circle if narrow or wide. | If PVCs, notify MD if bigeminy, trigeminy, multifocal, couplets, VT, >6/min. If any of these are occurring, check patient and consider doing a STAT ECG.  If escape beats/rhythms, check patient and consider doing a STAT ECG. May need pacing if significant bradycardia occurs. |
| **Please indicate any additional information** |  |  |

As you are all aware, rhythm interpretation is extremely easy when it’s a sinus rhythm; however, interpretation can be extremely difficult when rhythms are fast, irregular, and abnormal. Having taught these classes for over 25 years, I can honestly say that staff will do much better at describing the features of an abnormal rhythm rather than labelling the rhythm itself.

For example: rather than guessing what the rapid rhythm is they could describe the rhythm as a fast rhythm (“at a rate of…”) regular or irregular, and narrow or wide QRS complex. In smaller hospitals when the MD is not always in the building or at the unit, describing the rhythm in this fashion goes a long way. Hearing a nurse report “the rhythm is a wide complex tachycardia and irregular” along with the VS would likely cause the MD to think “WPW”. Hearing a nurse report “the rhythm is a narrow complex, regular tachycardia with a sudden onset” along with the VS, would likely cause the MD to think SVT (possible ?Atrial Tachycardia ?AVRT ?AVNRT). With SVT, diagnosing the actual rhythm is often challenging even for the most experienced practitioner, but knowing the interventions is really what it comes down to for the entire health care team.

Another example: rather than guessing what kind of AV block: the nurse could describe a “regular bradycardia (‘at a rate of, say 40’) and irregular PR intervals with a wide or narrow QRS complex”. Ideally, we want nurses to know AV blocks, but they are often forgotten because they’re not seen on a regular basis. I would suggest you print a copy of the **QRS Tips for AV Blocks** off our website at [www.qrs-education.com](http://www.qrs-education.com). This Tip Sheet is a super valuable tool that I have put together quite some time ago and has been trialed and liked by many participants at my courses. Post this Tip Sheet on your units and ECG machines.

So, in this Rhythm Assessment Documentation tool, I have kept the key pieces of rhythm interpretation: Rate, Regularity, Intervals, ST Segment. Plus I have added the 3rd column that includes action guidelines for the nurses to consider/take. These might have to be altered slightly; for example: if your telemetry nurses require an order to do an ECG, then the order of actions would need to be adjusted to reflect your hospital policy.