

THOMPSON HEALTH · NURSING EDUCATION

Dysrhythmia Recognition & Response

Student Follow-Along Coursebook

CLASS EDITION · 2026

F.F. Thompson Hospital · Canandaigua, NY
For educational use during class presentation
Follow along as your instructor covers each topic

Name:

Unit / Department:

Class Date:

This workbook follows the live class presentation. Fill in blanks during lecture. Use the notes spaces to capture what your instructor emphasizes.

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How to use this booklet: Your instructor will present each module using the course slides. As they teach, fill in the blanks in each section. The blanks are clues — they mark the most important facts to remember. Each module includes a practice strip — apply what you just learned before moving on.

Why AV Blocks & Pacemakers Come First: *Understanding why conduction can fail — and how we compensate — makes every subsequent rhythm click into place.* Learn the blocks, then the 5-step method will feel like second nature.

THE CLINICAL MANTRA

Recognize → Assess → Act. Every rhythm you learn leads to a clinical decision. Rate and rhythm on paper only matter in the context of how your patient looks.

The Clinical Approach

The three-step mantra: Recognize → Assess → Act

Always treat the patient, not the monitor

Signs of instability: hypotension, chest pain, dyspnea / shortness of breath, altered level of consciousness

The Electrical Pathway

Fill in the conduction pathway in order:



Pacemaker Hierarchy

Pacemaker Site	Intrinsic Rate	Resulting Rhythm If Primary
SA Node	<u>60</u> – <u>100</u> bpm	Normal Sinus Rhythm
AV Junction	<u>40</u> – <u>60</u> bpm	<u>Junctional</u> rhythm
Ventricles	<u>20</u> – <u>40</u> bpm	Idioventricular rhythm

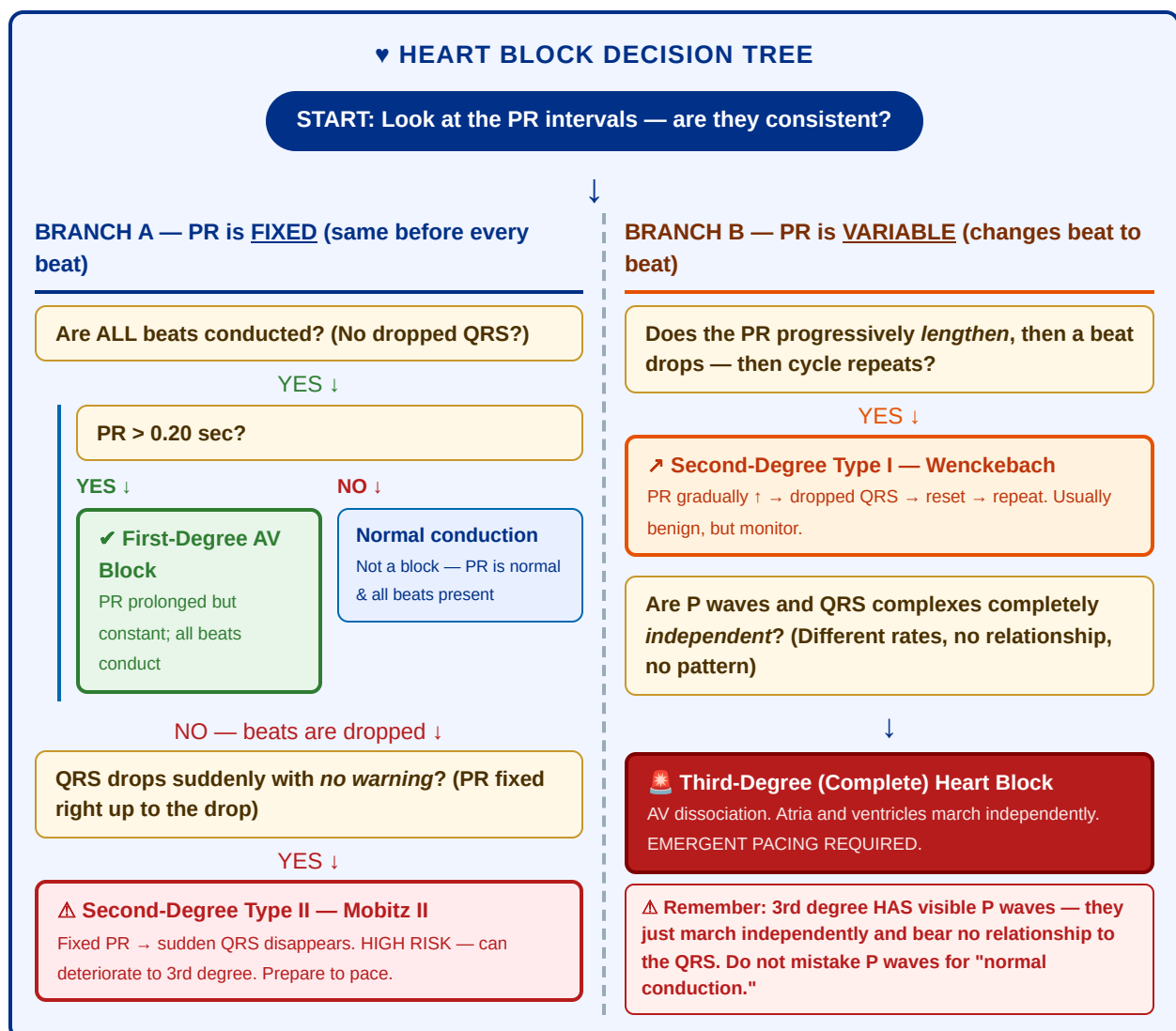
KEY POINT

Higher pacemakers **suppress** lower ones. If the SA node fails, the AV junction takes over — but at a slower rate. Each backup pacemaker is a safety net, not a normal state.

NOTES

All AV blocks share one feature: delayed or impaired conduction between atria and ventricles.

Block Type	PR Interval	Dropped Beats?	QRS	Risk Level
1st Degree	> <u>0.20</u> sec, constant	None	Narrow	<u>Low — benign</u>
2nd Degree Type I (Wenckebach)	Progressively <u>lengthens</u>	Yes — <u>period ically</u>	Usually narrow	<u>Low–moderate</u>
2nd Degree Type II (Mobitz II)	<u>Normal/constant</u> (fixed)	Yes — <u>sudden ly</u>	Often wide	<u>High</u> — can progress to 3rd degree
3rd Degree (Complete)	<u>Variable/absent</u> (no relationship)	Complete dissociation	Wide (ventricular) or narrow (junctional)	<u>Critical</u> — emergent pacing



Wenckebach (Type I) Clues

PR gets longer (progressively lengthens) then drops a beat

Cycle then resets

The RR intervals get progressively shorter

Location: usually at AV node

Generally benign (benign / dangerous)

Mobitz II Clues

PR interval is constant/fixed until a beat drops

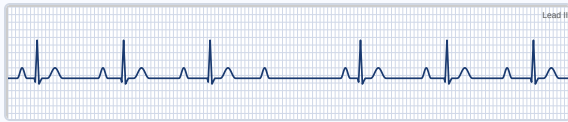
No warning — the QRS just disappears

Location: below the AV node (Bundle of His)

Can deteriorate to complete (3rd degree) heart block

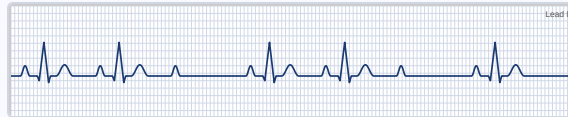
Action: prepare for pacing

► STRIP: IDENTIFY — WENCKEBACH OR OTHER?



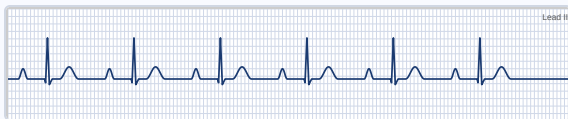
RATE RHYTHM INTERPRETATION ACTION

► STRIP: FIXED PR OR LENGTHENING?



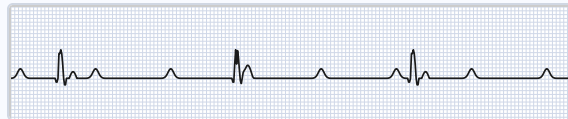
RATE RHYTHM INTERPRETATION ACTION

► STRIP: IS THE PR INTERVAL PROLONGED?



RATE RHYTHM INTERPRETATION ACTION

► STRIP: ARE P WAVES AND QRS RELATED?



RATE RHYTHM INTERPRETATION ACTION

KEY POINT — 3RD DEGREE BLOCK

Complete AV dissociation: P waves and QRS complexes march on independently. The atrial rate is **faster** than the ventricular rate. This is a medical emergency — the ventricles are running on their own escape rhythm.

NOTES

Recognizing Paced Rhythms

A pacemaker spike appears as a sharp vertical mark

Atrial pacing: spike before P wave

Ventricular pacing: spike before QRS (wide QRS)

Dual-chamber: 2 spikes per beat

A paced QRS is wide (narrow / wide)

Types of Pacemakers

Transcutaneous:
external, non-invasive, used in emergencies
(temporary, external)

Transvenous: temporary, inserted via central vein

Permanent: implanted, subcutaneous generator

VVI mode: paces V, senses V, inhibits on demand

Pacemaker Malfunctions

Failure to Capture:

Spike present but no QRS (myocardial response) follows

Causes: lead displacement, increased threshold / exit block, threshold change

Action: increase output / reposition lead

Failure to Sense:

Pacemaker fires despite / on top of a native beat (can't "see" it)

Appears as: spikes in inappropriate places

Risk: R-on-T → ventricular fibrillation

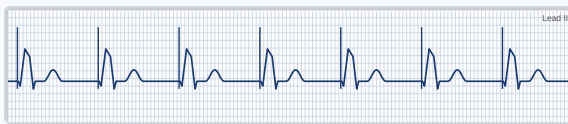
Failure to Pace:

No spike when one is expected

Causes: battery depletion, lead fracture/displacement

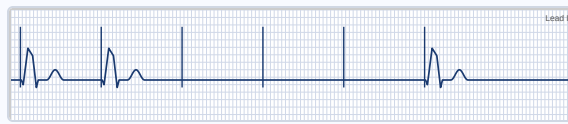
Action: troubleshoot pacemaker; apply transcutaneous backup

► STRIP: FIND THE PACER SPIKES



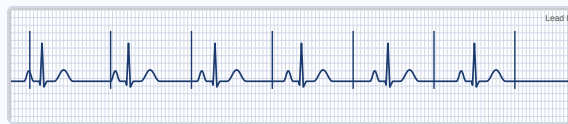
RATE RHYTHM INTERPRETATION ACTION

► STRIP: CAPTURE PRESENT?



RATE RHYTHM INTERPRETATION ACTION

► STRIP: ANY SENSING ISSUES?



RATE RHYTHM INTERPRETATION ACTION

KEY POINT

Capture = spike followed by a P wave or QRS complex. If you see a pacemaker spike without a following deflection → **failure to capture**. Always assess the patient — is the underlying rate adequate without pacemaker support?

NOTES

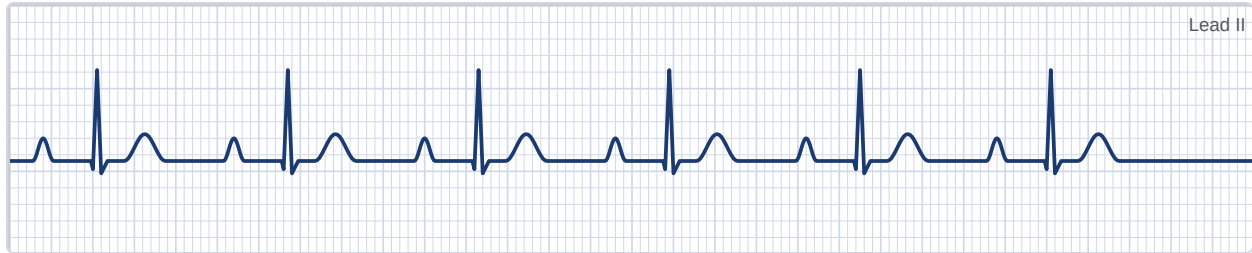
Independent Practice — Break

1

Heart Blocks & Pacing · Complete independently · Review with class after break

Interpret each strip using your clinical observation skills. Tip: We'll introduce a systematic 5-step approach in Module 4 — you'll use it for all future strips.

Strip 1



Rate

Rhythm

P Waves

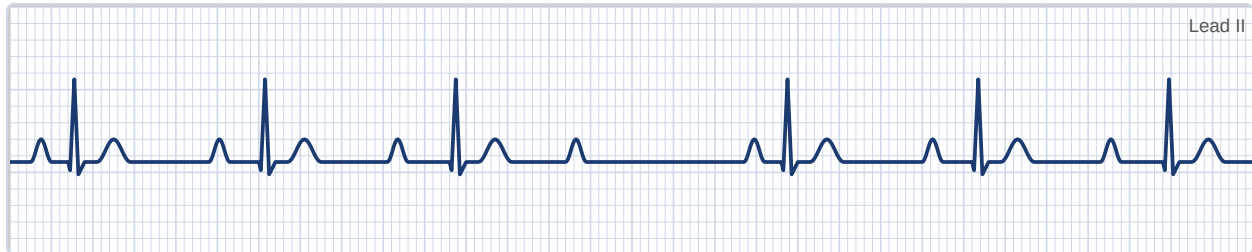
PR Interval

QRS Width

Interpretation

Clinical Action

Strip 2



Rate

Rhythm

P Waves

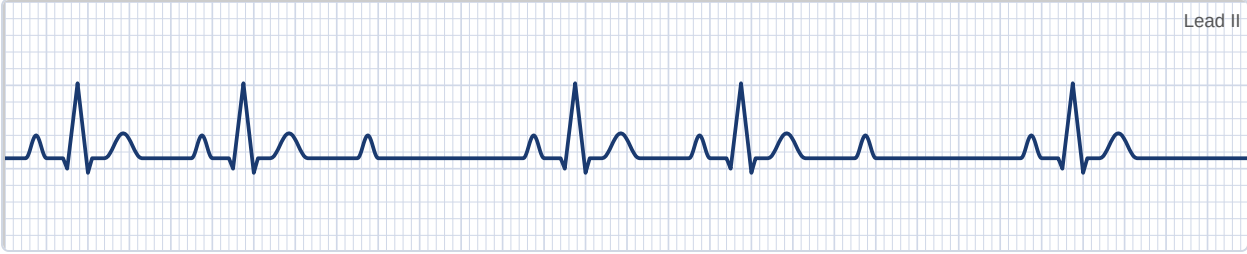
PR Interval

QRS Width

Interpretation

Clinical Action

Strip 3



Rate	Rhythm	P Waves
PR Interval	QRS Width	
Interpretation	Clinical Action	

Strip 4



Rate

Rhythm

P Waves

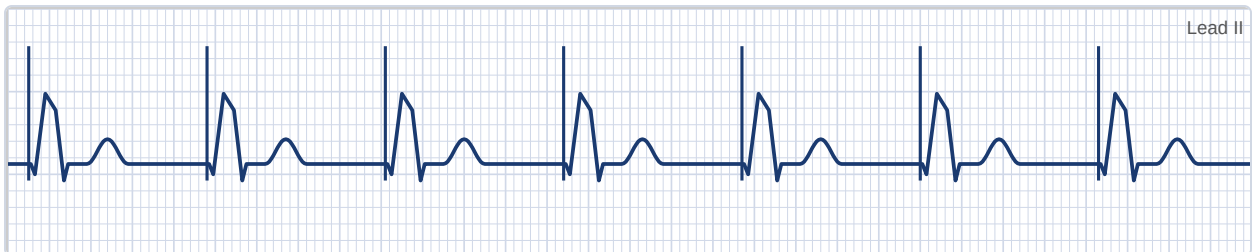
PR Interval

QRS Width

Interpretation

Clinical Action

Strip 5



Rate

Rhythm

P Waves

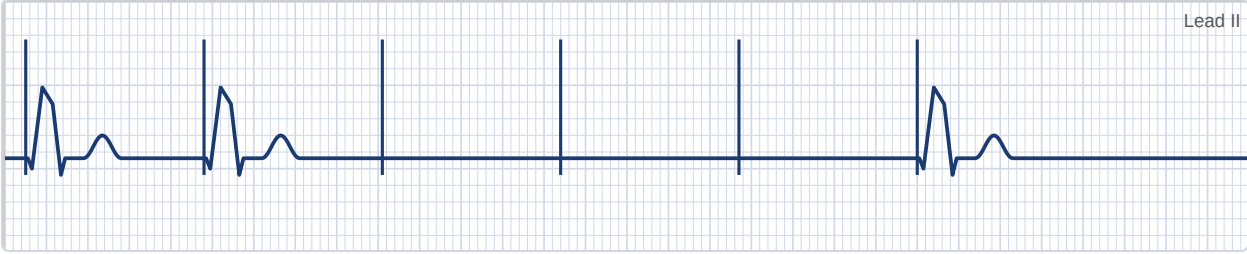
PR Interval

QRS Width

Interpretation

Clinical Action

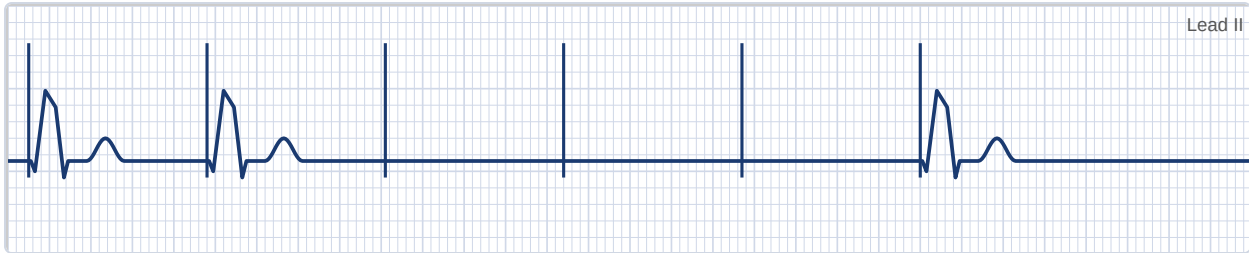
Strip 6



Rate	Rhythm	P Waves
PR Interval	QRS Width	
Interpretation	Clinical Action	

Clinical Scenario

72-year-old male admitted for syncope. History: dual-chamber pacemaker implanted 2 years ago for complete heart block. Current vitals: HR 32, BP 88/52, SpO₂ 94% RA, confused and diaphoretic.



1. What rhythm is shown? _____

2. What is the rate? _____

3. Is this patient stable or unstable based on HR 32, BP 88/52, and confusion?

4. What is your FIRST nursing action? _____

ECG Paper — Horizontal (Time)

1 small box = 0.04 seconds

1 large box = 0.20 seconds

5 large boxes = 1 second(s)

Standard paper speed = 25 mm/sec

ECG Paper — Vertical (Amplitude)

1 small box = 0.1 mV

1 large box = 0.5 mV

Standard: 10 mm = 1 mV

Normal Intervals

Interval	Normal Range
P wave	< <u>0.12</u> sec
PR interval	<u>0.12</u> – <u>0.20</u> sec
QRS complex	< <u>0.12</u> sec
QT interval	< <u>0.44</u> sec (HR dependent)

PR in small boxes: 3 to 5 boxes

QRS in small boxes: < 3 boxes

Waveform Meanings

Waveform / Interval	Electrical Event	What it means clinically
P wave	<u>Atrial depolarization</u>	Atria contract
QRS complex	<u>Ventricular depolarization</u>	Ventricles contract
T wave	<u>Ventricular repolarization</u>	Ventricles reset
PR interval	Atrial depolarization + <u>AV node delay</u>	AV node conduction time

KEY POINT

Normal PR = 0.12–0.20 sec (3–5 small boxes). Normal QRS < 0.12 sec (< 3 small boxes). Wide QRS means the signal traveled an abnormal path through the ventricles. **Now that you've seen what blocks look like — a prolonged PR takes on new meaning!**

NOTES

Apply these steps in order for every rhythm strip. Write the step name in each blank.

1 Step 1: Rhythm
 Is the rhythm regular or irregular?
 Method:
march out RR intervals (caliper or pen method)

2 Step 2: Rate
 Count QRS complexes in 6-second strip ×
10
 Or: $300 \div$ large boxes between beats

3 Step 3: P Waves
 Are they present? Y/N
 Upright? Y/N One per QRS? Y/N

4 Step 4: PR Interval
 Normal range: 0.12 – 0.20 sec
 Consistent or changing?
note if constant, lengthening, or absent

5 Step 5: QRS Width
 Normal QRS is narrow (narrow / wide) Wide QRS suggests:
ventricular origin, bundle branch block, or aberrant conduction

Rate Calculation — 6-Second Method

Count the number of QRS complexes in a 6-second strip

Multiply by 10 to get beats per minute

6 seconds = 30 large boxes on standard ECG paper

This method works best for irregular rhythms

KEY POINT

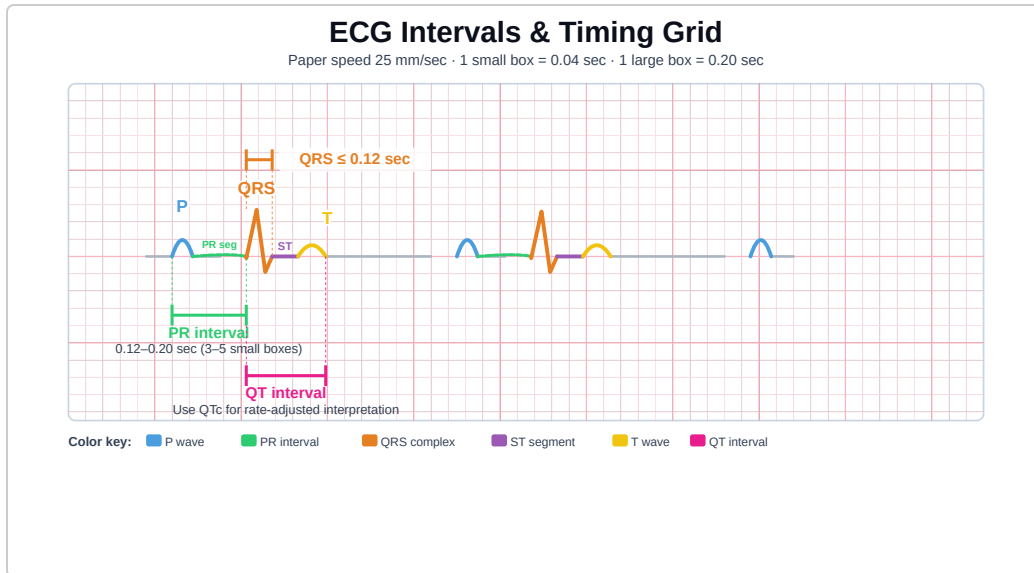
Use the same 5 steps on every strip, every time. Consistency prevents errors. After every interpretation: *"Is this patient stable?"*

Quick reminder: Rhythm → Rate → P Waves → PR Interval → QRS Width → Interpret → Act

NOTES

Practice: Reading Measurements

Use the ECG intervals diagram below. Find each feature and record your measurements.



1. Find a P wave — count small boxes: ~2
boxes = 0.08 sec

2. PR interval (start of P → start of QRS): ~4
boxes = 0.16 sec

3. QRS width (small boxes): ~2 boxes =
0.08 sec

4. Is the PR interval normal? (Normal = 3–5 boxes / 0.12–0.20 sec): Yes — normal

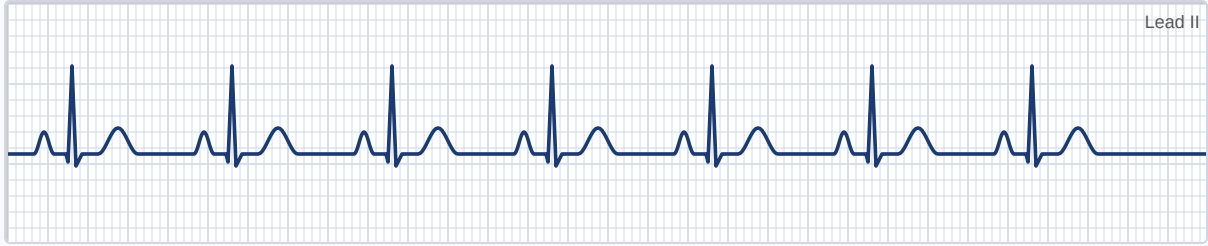
QUICK REFERENCE

P wave: < 0.12 sec (< 3 small boxes)
 PR interval: 0.12–0.20 sec (3–5 boxes)
 QRS: < 0.12 sec (< 3 boxes)
 QT: < 0.44 sec (varies with HR)

Practice — Apply the 5 Steps

Use this strip. Walk through all 5 steps out loud before writing your interpretation.

▶ APPLY THE 5-STEP METHOD — IDENTIFY THIS RHYTHM



STEP 1 — RHYTHM
(REGULAR OR
IRREGULAR?)

**STEP 2 — RATE (6-SEC
METHOD)**

STEP 3 — P WAVES
(PRESENT? UPRIGHT? 1
PER QRS?)

STEP 4 — PR INTERVAL
(NORMAL / LONG /
VARIABLE?)

STEP 5 — QRS WIDTH
(NARROW OR WIDE?)

Interpretation: _____

NOTES

Rhythm	Rate	P Waves	PR / QRS	Common Cause / Action
Normal Sinus Rhythm	60 – 100 bpm	Upright, 1 per QRS	Normal	No action needed
Sinus Bradycardia	< 60 bpm	Normal	Normal	Treat if <u>symptomatic</u>
Sinus Tachycardia	> 100 bpm	Normal	Normal	Treat the <u>underlying cause</u>
Sinus Arrhythmia	60–100 bpm	Normal	Normal	Rate varies with <u>respiration</u>

Key Teaching Points

All sinus rhythms originate in the SA (sinoatrial) node

Sinus bradycardia causes: increased vagal tone, hypothyroidism, medications, athletes

Sinus tachycardia causes: pain, fever, anxiety, hypovolemia, sepsis — always find the cause

Sinus tachycardia *with hemodynamic instability*: consider fluid resuscitation; treat underlying cause

A wandering pacemaker has ≥ 3 different P-wave morphologies

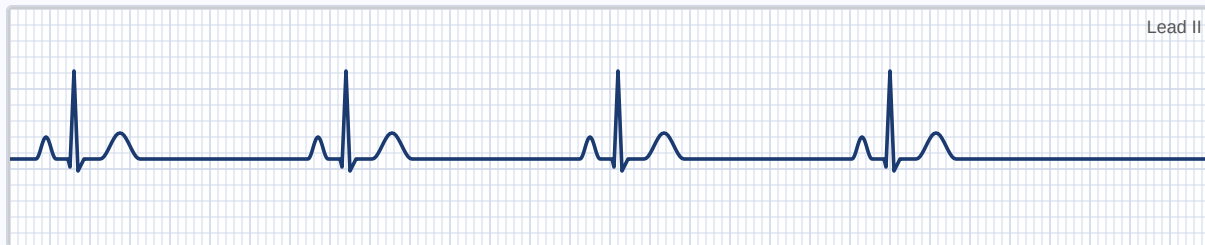
KEY POINT — SINUS BRADY

A rate below 60 bpm is only an emergency if the patient is **symptomatic**. Athletes and sleeping patients may have heart rates in the 40s — this is normal for them.

KEY POINT — SINUS TACHY

Sinus tachycardia is always a **response** to something (pain, fever, fear, hypovolemia). Treat the cause, not the number on the monitor.

► PRACTICE: SINUS RHYTHM — FAST, SLOW, OR NORMAL?



STEP 1 — RATE

STEP 2 — RHYTHM

STEP 3 — P WAVES / PR

STEP 5 — QRS / INTERPRETATION

CLINICAL SCENARIO — PRACTICE

Patient: HR 48 · BP 108/68 · SpO₂ 97% · Alert & oriented · No complaints

This rhythm strip shows sinus bradycardia. What is the most appropriate action?

Is this patient hemodynamically stable? Yes

Does the rate alone require treatment? No

What is your action? Continue monitoring; document; notify provider if symptomatic

NOTES

PAC (Premature Atrial Contraction)

Origin: ectopic focus in the atria

P wave: present but different morphology (abnormal shape)

Appears earlier than expected

QRS: usually narrow (narrow / wide)

Clinical: usually benign / no treatment needed

Atrial Flutter

Atrial rate: approximately 300 bpm

Classic pattern: flutter/sawtooth waves (sawtooth)

Conduction ratio: often 2:1 or 4:1

Ventricular rate with 4:1 block \approx 75 bpm

Risk: can convert to atrial fibrillation

Atrial Fibrillation

Atrial rate: 350 – 600 bpm (chaotic)

Ventricular rhythm: irregularly irregular

P waves: absent, replaced by fibrillatory (f) waves

Major risk: thrombus → embolism (stroke)

Anticoagulation decision: use CHA₂DS₂-VASc score

SVT (Supraventricular Tachycardia)

Rate: 150 – 250 bpm

Onset: sudden / gradual (circle one)

P waves: absent / hidden in QRS or retrograde

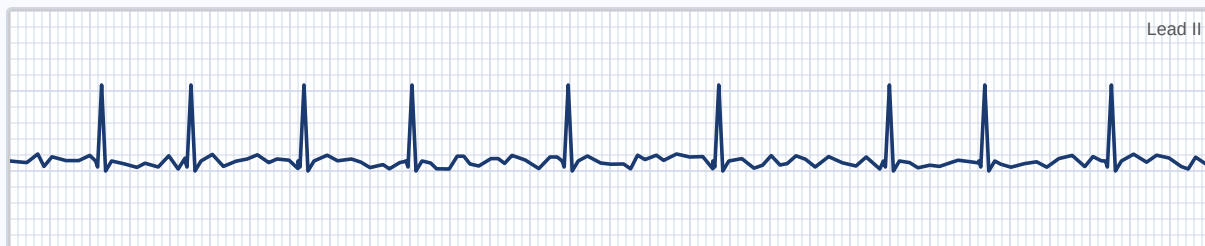
First intervention: vagal maneuver (Valsalva)

Drug of choice: adenosine (6 mg IV rapid push)

KEY POINT — AFIB

The hallmark of AFib is an **irregularly irregular** ventricular rhythm with no identifiable P waves. The big danger isn't the rate — it's the thrombus that forms in the non-contracting atrium.

▶ PRACTICE: IDENTIFY THE ATRIAL RHYTHM — P WAVES PRESENT?



STEP 1 — RATE

STEP 2 — RHYTHM

STEP 3 — P WAVES / PR

STEP 5 — QRS / INTERPRETATION

NOTES

When the AV Junction Takes Over

Junctional rhythms occur when the SA node fails or is suppressed

Junctional escape rate: 40 – 60 bpm

Accelerated junctional rate: 60 – 100 bpm

Junctional tachycardia rate: > 100 bpm

P Wave Clues in Junctional Rhythm

P waves may be: (1) before QRS (inverted in II, III, aVF) (before QRS, inverted) or

(2) buried in QRS (not visible) (buried in QRS, not visible) or

(3) after QRS (retrograde) (after QRS)

When P wave precedes QRS, PR interval is shorter than normal (< 0.12 sec)

QRS width: usually narrow (narrow / wide)

Clinical Significance

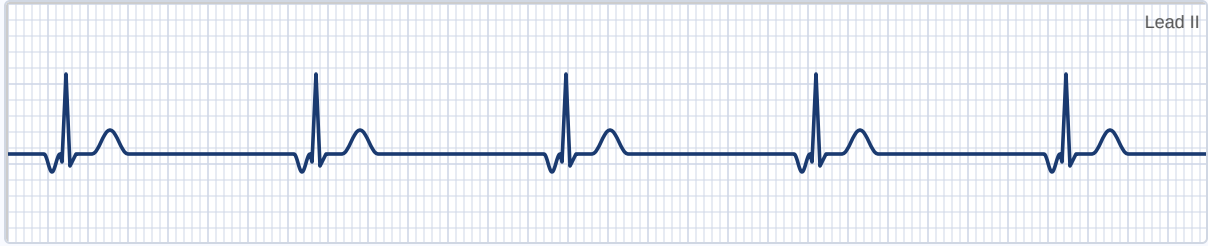
Type	Rate	Priority	Common Cause
Junctional Escape	40–60 bpm	Monitor; treat underlying cause	SA node failure, vagal tone
Accelerated Junctional	60–100 bpm	Monitor	Dig toxicity, inferior MI, post-cardiac surgery
Junctional Tachycardia	> 100 bpm	<u>Urgent — treat</u>	Dig toxicity, ischemia

KEY POINT

Junctional rhythms are **escape rhythms** — the junction fires because a higher pacemaker failed. The key question: why did the SA node fail? Look for medications, ischemia, or high vagal tone.

Inverted P wave rule: If P waves are inverted in leads II, III, and aVF → the impulse is going up the atria instead of down → junctional or ventricular origin.

▶ PRACTICE: WHERE ARE THE P WAVES?



STEP 1 — RATE

STEP 2 — RHYTHM

STEP 3 — P WAVES / PR

STEP 5 — QRS /
INTERPRETATION

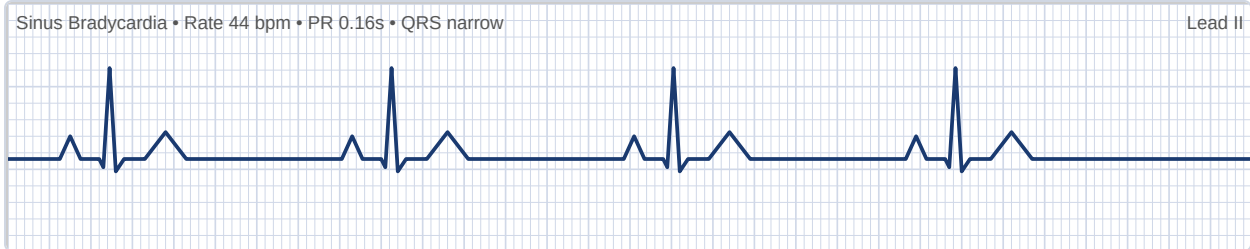
NOTES

Independent Practice — Break 2

Atrial & Junctional Rhythms · Complete independently · Review with class after break

Apply the **5-Step Rhythm Method** to every strip: Rate → Rhythm → P Waves → PR Interval → QRS Width → Interpretation. Complete independently before the group review.

Strip 1



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

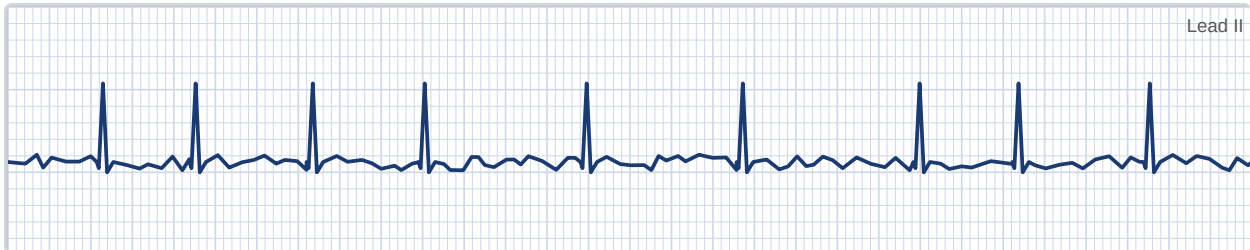
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 2



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

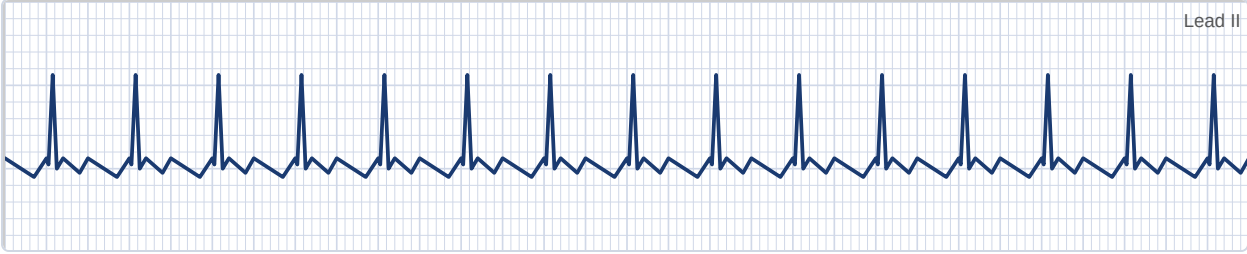
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 3



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

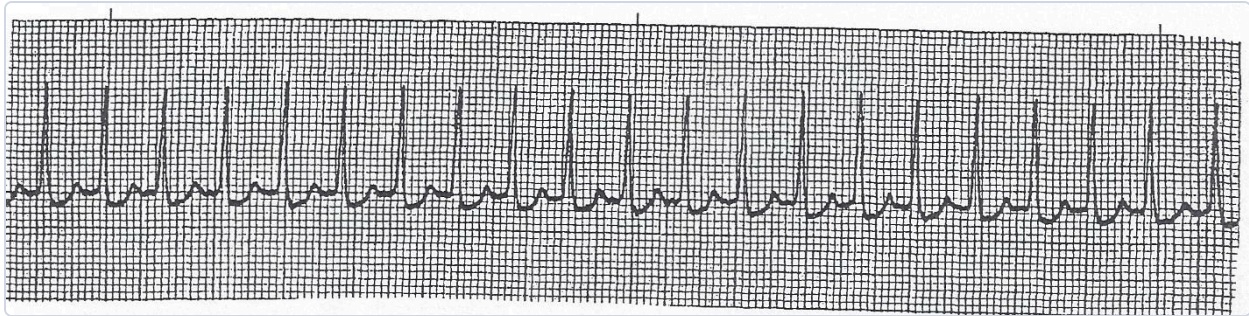
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 4



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

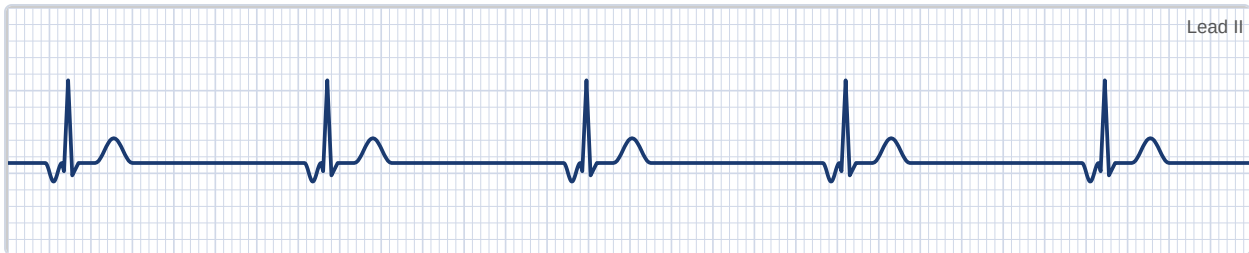
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 5



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

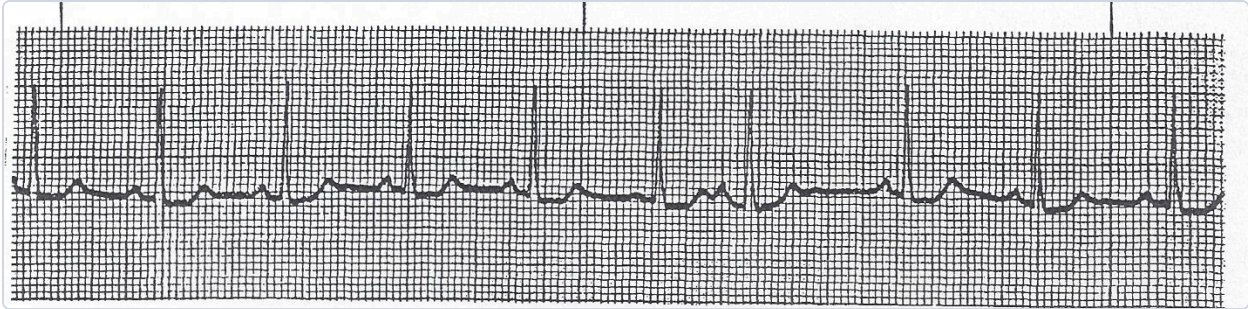
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 6



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

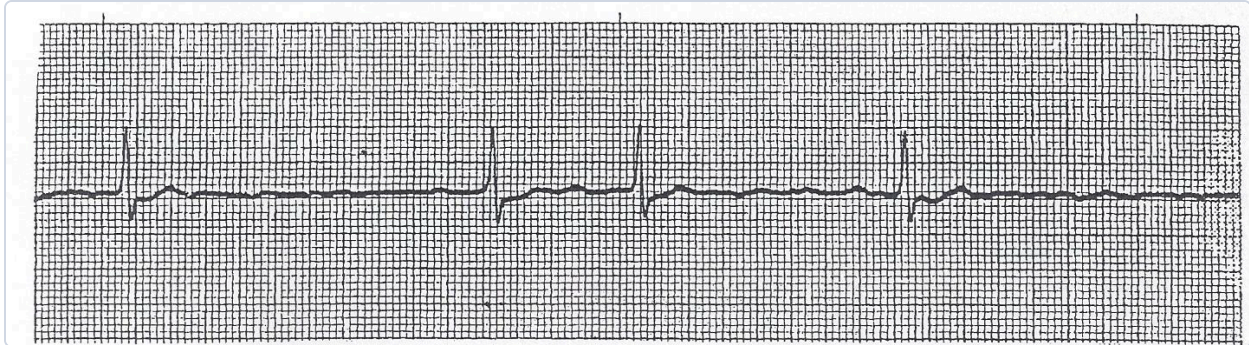
Step 5 — QRS Width

Interpretation

Clinical Action

Clinical Scenario

68-year-old female with known chronic AFib on anticoagulation therapy. Current vitals: HR 148, BP 106/72, SpO₂ 96% RA, alert and oriented. Complains of palpitations and mild fatigue.



1. What rhythm is shown? _____
2. What is the rate? _____
3. Is this patient stable or unstable based on HR 148, BP 106/72, and mental status?

4. What is your FIRST nursing action? _____

Rhythm	QRS Width	Rate	Key Feature	Immediate Action
PVC	> 0.12 sec	Varies	Wide, bizarre QRS, no P wave before	Monitor; treat if > 6 /min or runs
V-Tach (sustained)	Wide	> 100 bpm	≥ 3 consecutive PVCs	If stable: amiodarone ; if unstable: synchronized cardioversion
Ventricular Fib	No QRS	No pulse	Chaotic, no recognizable complexes	Immediate defibrillation + CPR
Idioventricular	Wide	20 – 40 bpm	Escape rhythm	Do NOT suppress; find cause
Asystole	None	0	Flat line / no electrical activity (flat line)	CPR, epinephrine, find cause

PVC Patterns — Know These

Unifocal PVCs: all look alike (same morphology) (same shape)

Multifocal PVCs: different shapes / morphologies — more concerning

Bigeminy: every 2nd beat is a PVC

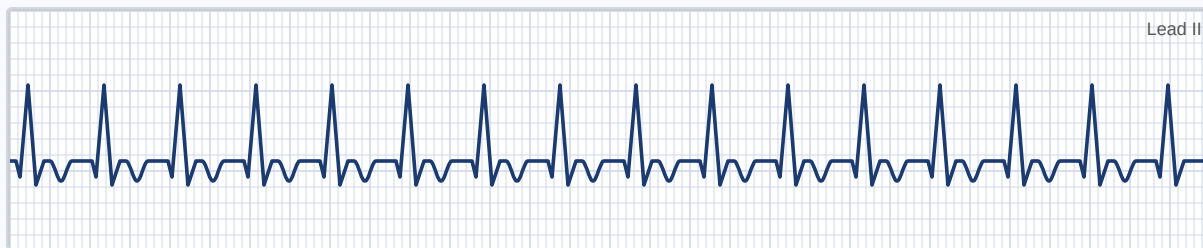
Trigeminy: every 3rd beat is a PVC

Couplet: 2 PVCs in a row

Triplet: 3 PVCs in a row

R-on-T phenomenon: PVC falls on the T wave → can trigger ventricular fibrillation

▶ PRACTICE: WIDE QRS — COUNT THE RATE, CHECK FOR P WAVES



STEP 1 — RATE

STEP 2 — RHYTHM

STEP 3 — P WAVES / PR

STEP 5 — QRS / INTERPRETATION

⚡ **Defibrillation** is the only definitive treatment for VFib and pulseless V-Tach. Begin CPR immediately while the defibrillator charges. Every second counts.

NOTES

Independent Practice — Break

3

Ventricular Rhythms · Complete independently · Review with class after break

Apply the **5-Step Rhythm Method** to every strip: Rate → Rhythm → P Waves → PR Interval → QRS Width → Interpretation. Complete independently before the group review.

Strip 1



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

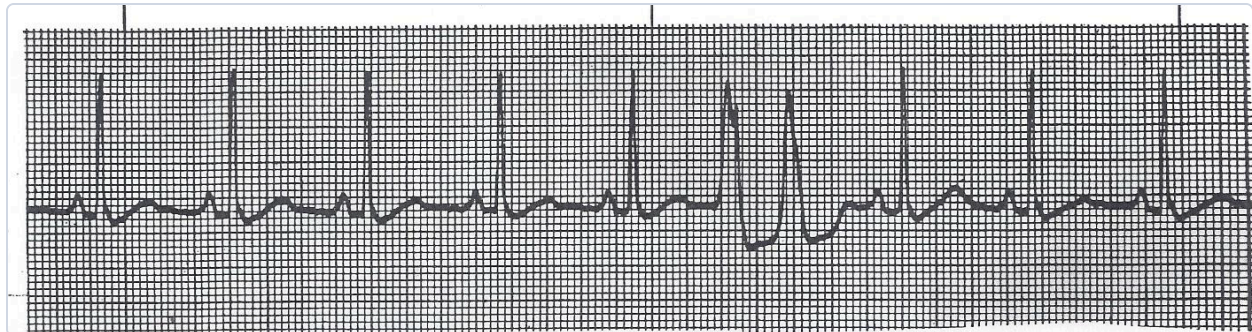
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 2



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

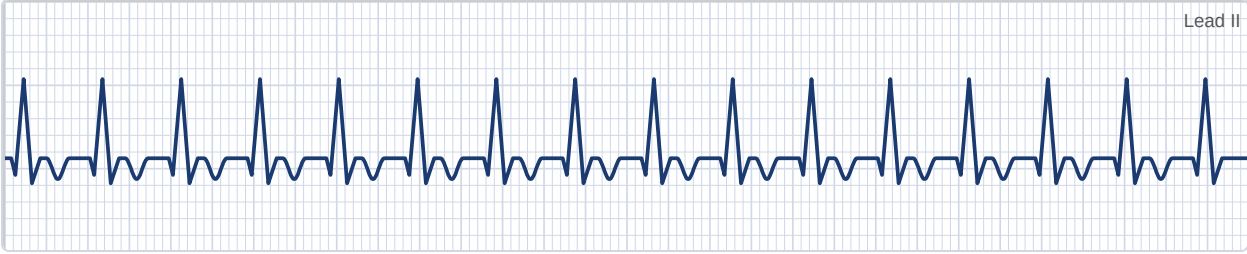
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 3



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

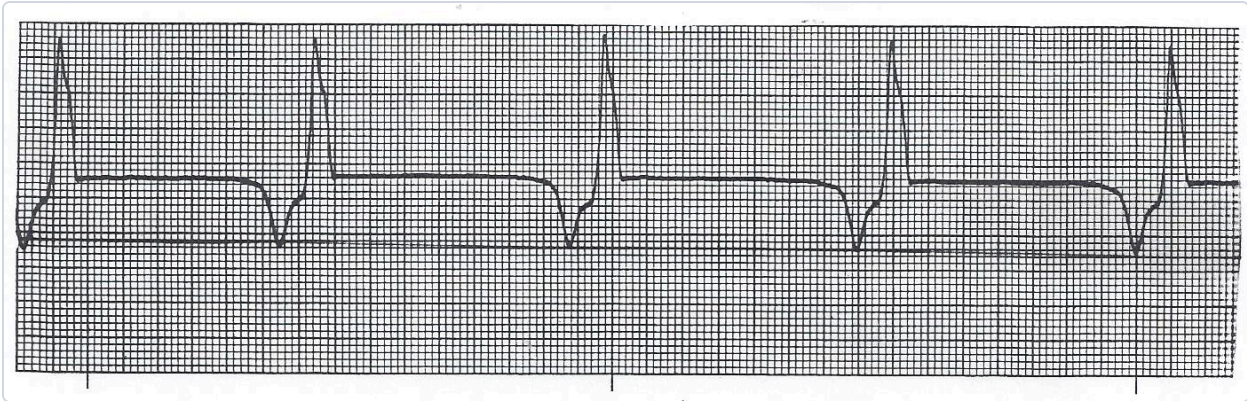
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 4



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

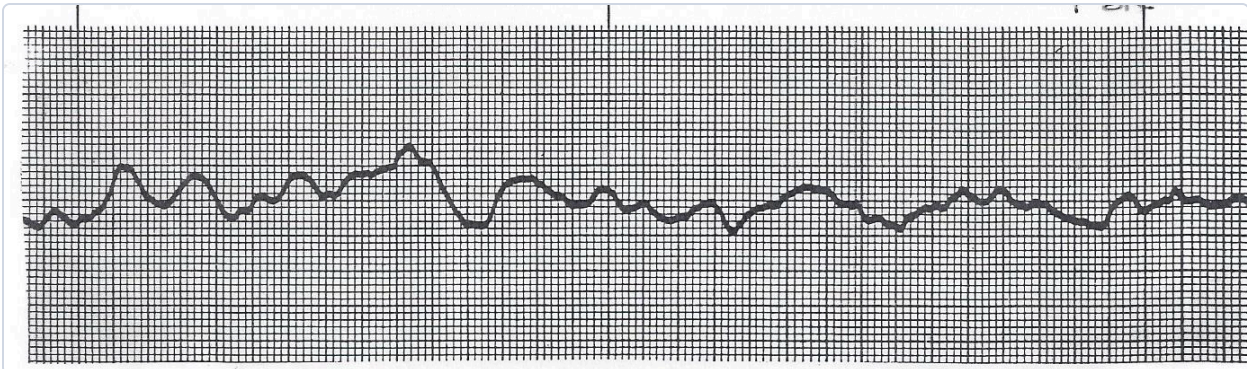
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 5



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

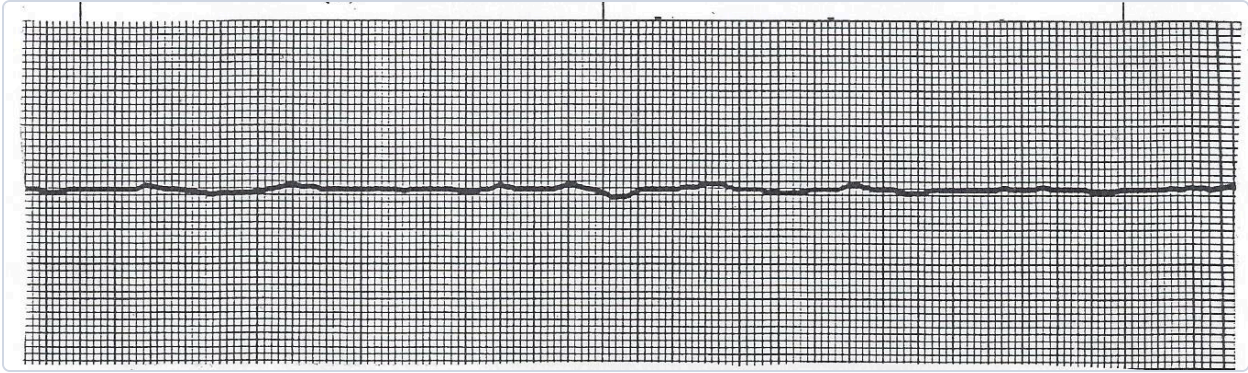
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 6



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

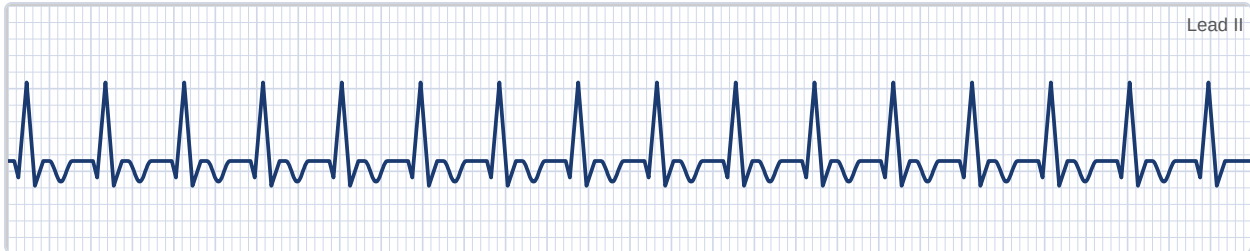
Step 5 — QRS Width

Interpretation

Clinical Action

Clinical Scenario

Post-operative day 1 patient found unresponsive in bed. Monitor shows wide complex tachycardia at rate 180 bpm. No palpable pulse. Code team has been activated.



1. What rhythm is shown? _____
2. What is the rate? _____
3. What did the nurse find when checking for a pulse? _____
4. What is the appropriate treatment pathway for this rhythm without a pulse?

You see a rhythm on the monitor



STEP 1: Screen for Heart Block FIRST (Check PR interval)

Is the PR interval present and CONSISTENT?

PR progressively LENGTHENS → dropped QRS?

Cycle repeats (group patterns)

↳ **Wenckebach (Type I)**

PR FIXED → sudden dropped QRS?

No progressive change

↳ **Mobitz II (Type II) ⚠**

P waves & QRS completely UNRELATED (diff. rates)?

AV dissociation

↳ **3rd-Degree Block 🚨**

PR > 0.20 sec but ALL beats conduct?

No dropped beats

↳ **1st-Degree Block ✓**

↓ If no block pattern identified — continue to 5-Step Method below ↓

STEP 2: Apply the 5-Step Method

1 What is the RATE?

- ▶ **< 60** → Bradycardia branch
Sinus Brady / Junctional Escape / Idioventricular
- ▶ **60–100** → Normal rate
NSR / 1° Block / PAC / PVC
- ▶ **> 100** → Tachycardia branch
Sinus Tachy / SVT / AFib / VTach

2 Is rhythm REGULAR or IRREGULAR?

- ▶ **Irreg. irreg.** → Think AFib first
- ▶ **Regularly irreg.** → Group patterns suggest Wenckebach or PACs

3 Are P WAVES present?

- ▶ **None** → Junctional or Ventricular origin
- ▶ **Inverted** → Junctional (retrograde)
- ▶ **Sawtooth** → Atrial Flutter
- ▶ **Fibrillatory** → Atrial Fibrillation
- ▶ **Upright × 1** → Sinus origin likely

4 PR INTERVAL

- ▶ **0.12–0.20s** Normal — Sinus origin likely
- ▶ **> 0.20s** 1st Degree AV Block
- ▶ **< 0.12s** → Junctional or WPW
- ▶ **Absent / var.** → Block or Junctional/Ventricular

5 QRS WIDTH

- ▶ **< 0.12s** Narrow → Supraventricular origin
- ▶ **≥ 0.12s** Wide → Ventricular or aberrant SVT
- ▶ **Paced wide** Look for pacer spikes

Common Terminal Diagnoses

- | | | | |
|---|--|---|---|
| NSR | Sinus Brady | Sinus Tach | 1° Block |
| SVT / PSVT | AFib | AFlutter | Wenckebach |
| Junctional | PVCs | Mobitz II ⚠ | V-Tach |
| V-Fib 🚨 | 3° Block 🚨 | Idioventricular | |

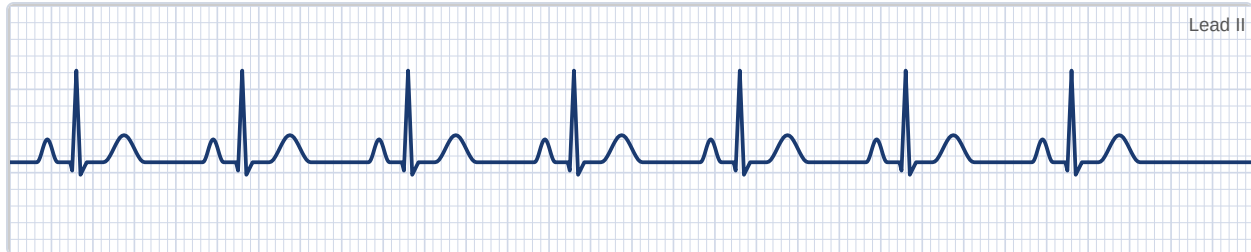
■ Green = Benign / Monitor ■ Orange = Monitor / Assess patient ■ Red = Urgent / Act

■ Dark Red = Emergency / Immediate intervention

Always: After identifying the rhythm — assess the patient. Rate and rhythm only matter in context. Ask: *"Is my patient hemodynamically stable?"*

Apply the **5-Step Rhythm Method** to every strip: *Rate* → *Rhythm* → *P Waves* → *PR Interval* → *QRS Width* → *Interpretation*. Complete all fields independently before asking your instructor.

Strip 1



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

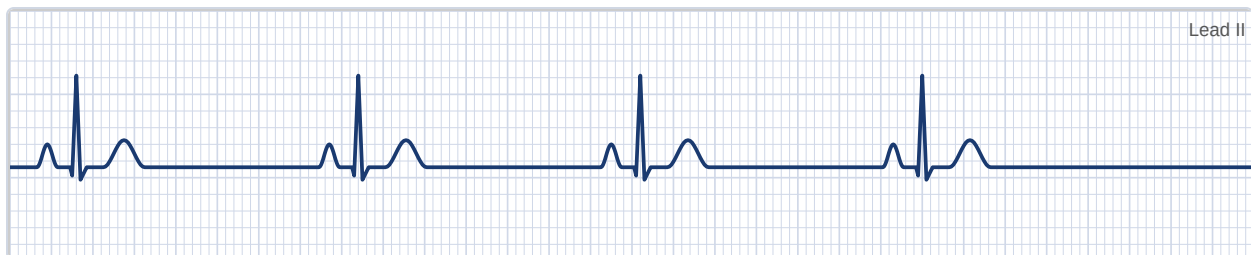
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 2



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

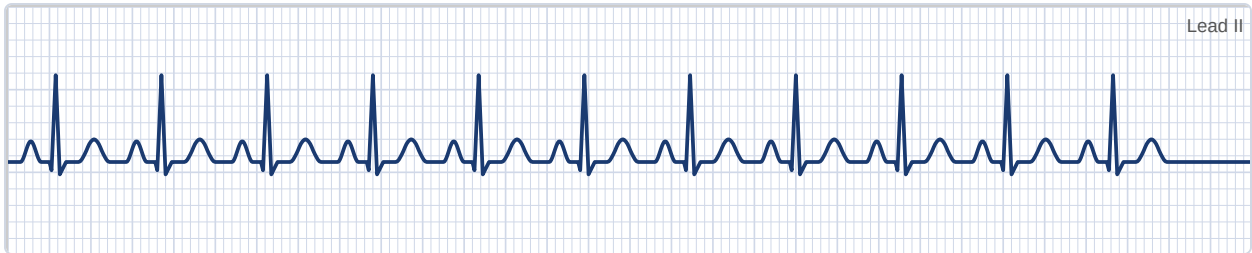
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 3



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

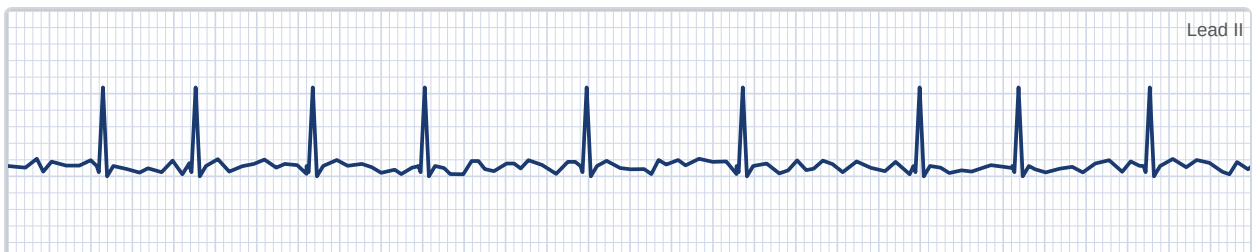
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 4



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

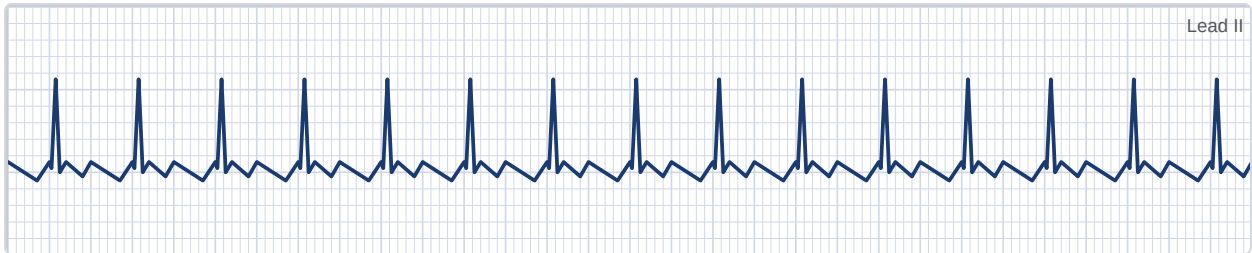
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 5



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

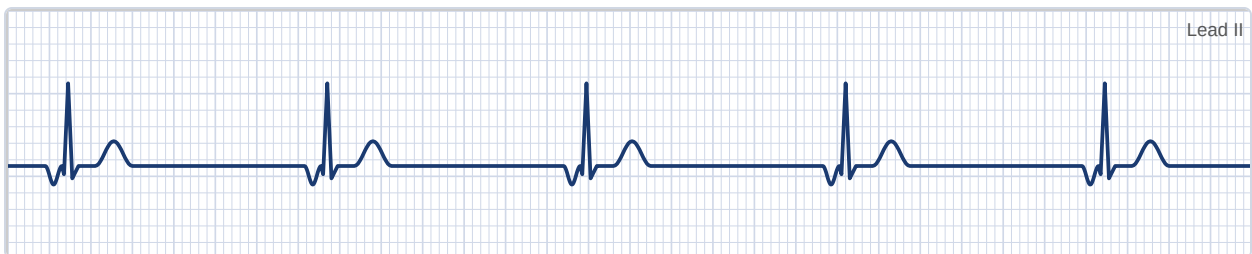
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 6



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

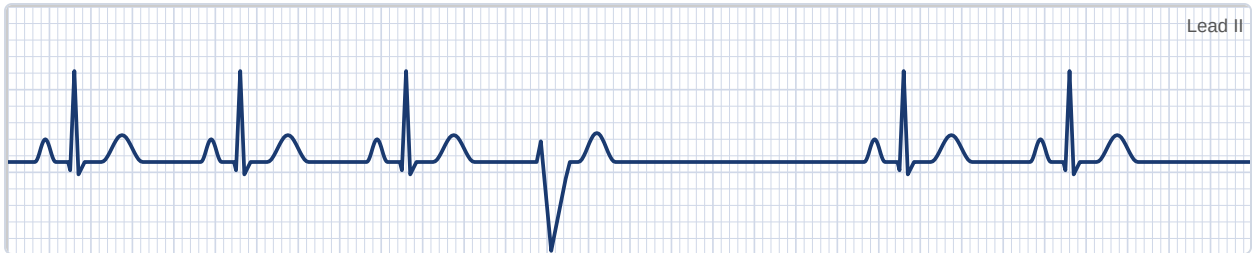
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 7



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

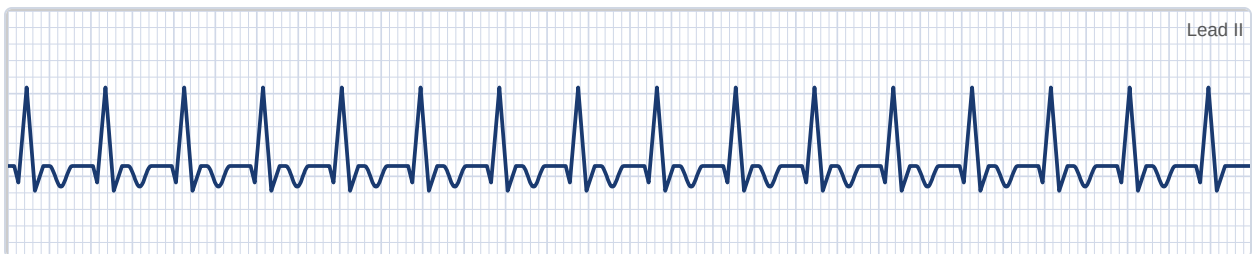
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 8



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

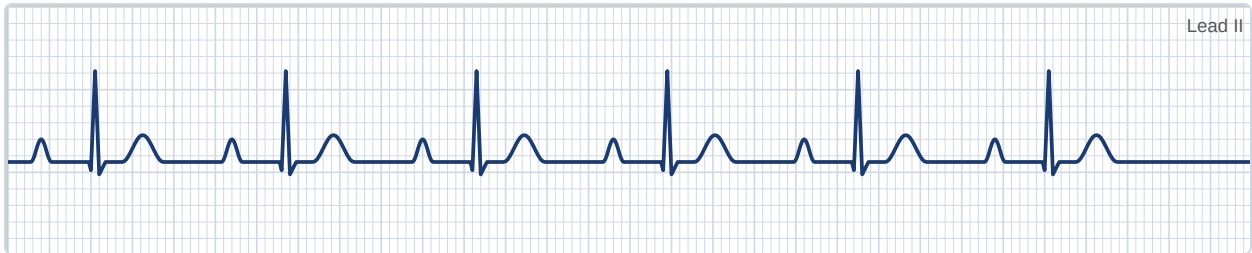
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 9



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

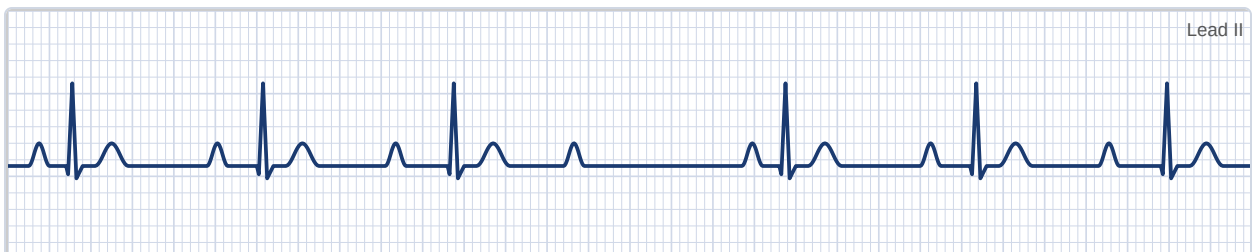
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 10



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

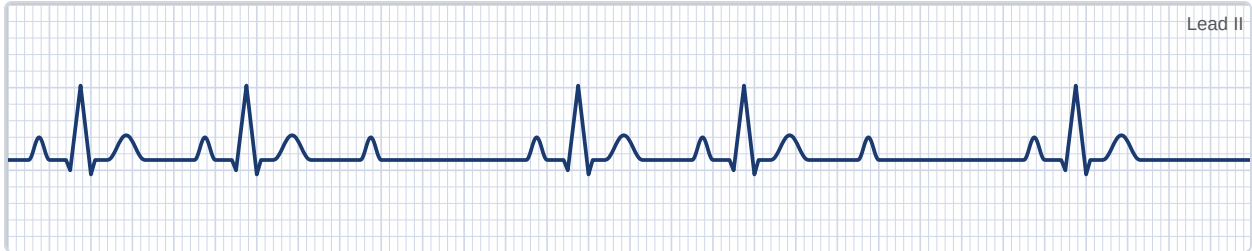
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 11



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 12



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 13



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

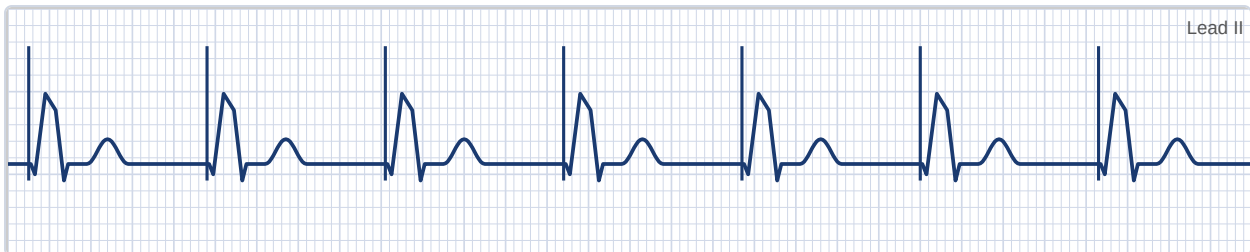
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 14



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

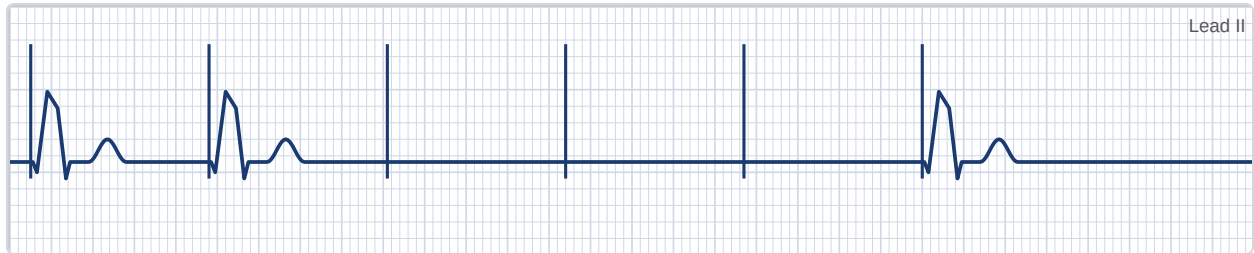
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 15



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

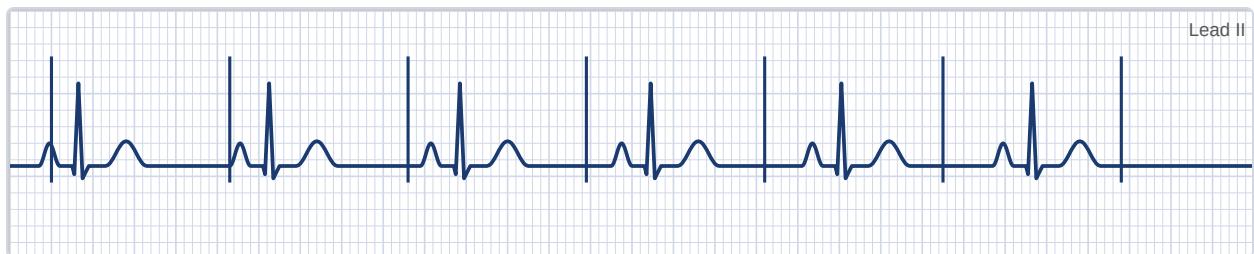
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 16



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

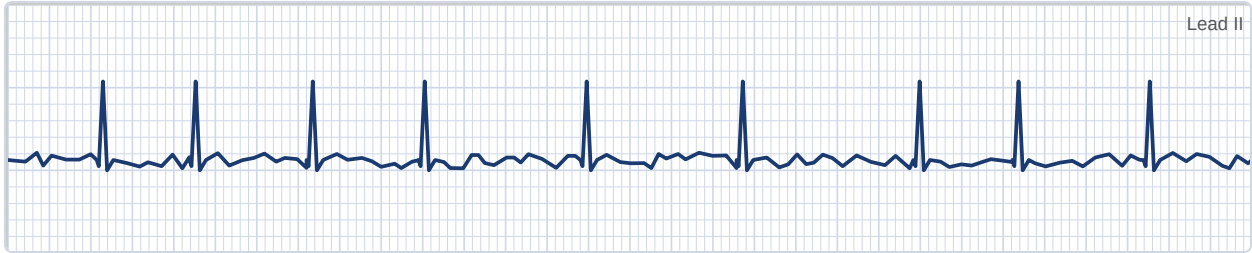
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 17



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

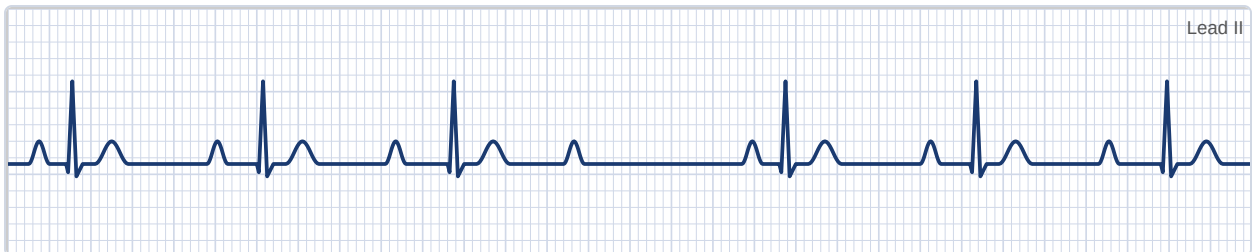
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 18



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 19



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

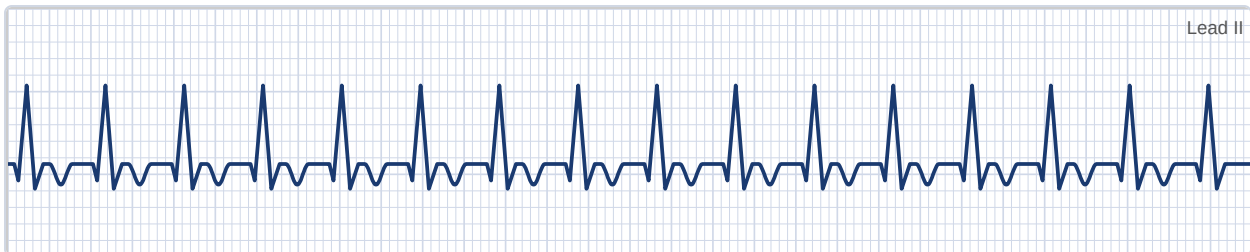
Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Strip 20



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Clinical Action

Well done! You've worked through 20 strips using the 5-step method. Rhythm interpretation is a skill built with repetition. Keep practicing, and always connect the rhythm to your patient's clinical picture.

Remember: Recognize → Assess → Act.

[← Back to Course \(Online Version\)](#)

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Dysrhythmia Recognition & Response ·

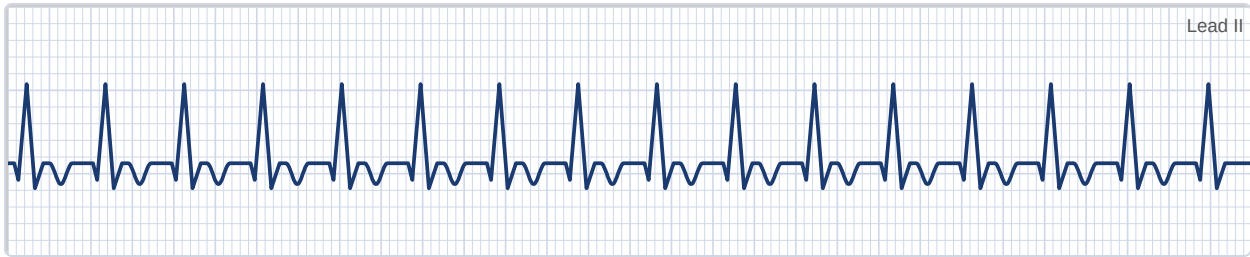
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Instructions — For each strip below, complete all three steps:

1. **Name the rhythm** using your 5-step method (Rate → Rhythm → P Waves → PR Interval → QRS)
2. **State the stability criteria** you would assess at the bedside (mental status, BP, SpO₂, symptoms)
3. **Describe your first action** — what would you do if this patient is stable? If unstable?

Strip A



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

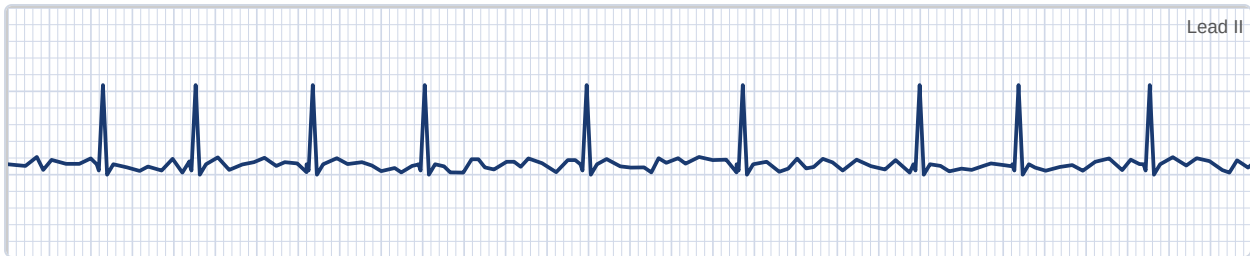
Interpretation

Stability criteria I would assess

If stable —
first action:

If unstable —
first action:

Strip B



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

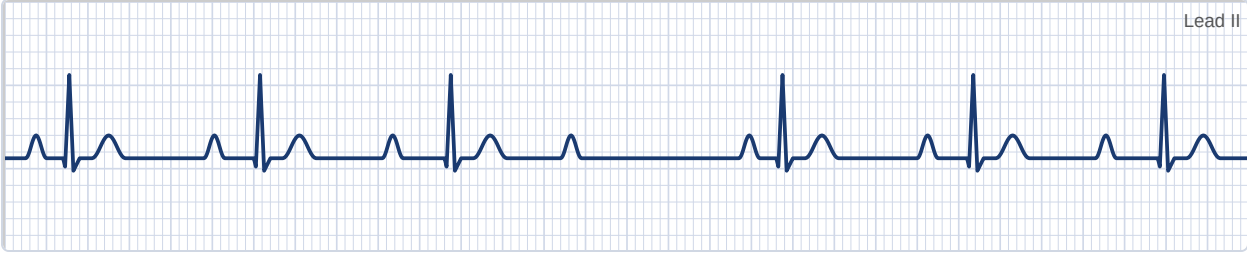
Interpretation

Stability criteria I would assess

If stable —
first action:

If unstable —
first action:

Strip C



Step 1 — Rate

Step 2 — Rhythm

Step 3 — P Waves

Step 4 — PR Interval

Step 5 — QRS Width

Interpretation

Stability criteria I would assess

If stable —
first action: _____

If unstable —
first action: _____

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