THE MIDWIFERY MINICEX – A VALUABLE CLINICAL ASSESSMENT TOOL FOR MIDWIFERY EDUCATION

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Assessment
miniCEX
Clinical Education

Abstract

Background
Midwifery students, clinicians and educators in Australia identified the need for improved feedback for midwifery students whilst they are on clinical placement; in particular formative assessment. The miniCEX or mini-clinical evaluation exercise is one approach to assessment that has been proven valid and reliable in medical education. The aim of this research was to develop, implement and evaluate a miniCEX tool for midwifery education.

Methods
Using an action research approach, this project engaged midwifery clinicians and midwifery students to adapt and implement the miniCEX in a postnatal ward environment. Focus groups were held to establish the clinical expectations and develop performance guidelines of students across the domains of midwifery practice, as well as evaluate their use in practice.

Findings
Evaluation of the midwifery miniCEX, including its applicability from the perspective of staff and students was positive. The miniCEX was found to be easy to use, time efficient and valuable for learning.

Discussion
The miniCEX is an innovative approach to assessment and feedback in midwifery education, and there is currently no identified evidence of it use in midwifery despite broad use globally in medical education.

Conclusion
The implementation of the midwifery miniCEX offers broad benefit to both midwifery students and midwifery clinicians and educators globally.
INTRODUCTION

Midwifery education in Australia has undergone significant change over the past ten years with the implementation of a Bachelor of Midwifery (three year program). Students enter this program of study with no nursing background and are often new to health-care services. This is a significant change for midwifery education whereby previously all midwifery students were registered nurses first. Anecdotally, these midwifery students have identified that the midwifery clinicians with whom they are placed are used to having learners with nursing skills, and some struggle to provide assessment and feedback across the spectrum of midwifery student capabilities. Therefore, with this new, more inexperienced cohort of midwifery students, the need for improved feedback and assessment whilst on clinical placement has become paramount.

Assessment and feedback are integral to effective teaching and learning (Broadfoot 2007). Assessment methods based on observation of routine encounters are the most effective in the clinical setting (Norcini 2007; van der Vleuten et al. 2010). The miniCEX or mini-clinical evaluation exercise is one approach to assessment that has been proven valid and reliable in medical education (Norcini 2007; Fernando et al. 2008). The miniCEX as an assessment method for medical students is now used worldwide and has been adapted to different medical contexts. Norcini (2007) encourages the modification of the miniCEX to suit different contexts to ensure the relevance of the method for any particular student group. There is currently no evidence found of use of the miniCEX in midwifery education. The aim of this research was to develop, implement and evaluate a miniCEX tool for midwifery education. The adaption and implementation of the miniCEX for midwifery offers broad benefit to midwifery students, clinicians and educators globally to provide relevant and timely assessment and feedback to improve student learning.

BACKGROUND/LITERATURE

Clinical education has a long tradition in the health professions as they are practice-based professions and cannot be learnt in the university alone. The intent of clinical education is to enable students to go into the real workplace to learn the practice of their profession and to 'integrate' their university learnt academic knowledge into the occupational knowledge required for effective professional practice. These knowledges are more broad than simply ‘knowledge, skills and attitudes’. Professional practice requires

- (1) conceptual knowledge which is not just about content knowledge but knowledge about concepts, facts and propositions;
- (2) procedural knowledge which is the integration of technical skills in the context of understanding how and when they apply; and
- (3) dispositional knowledge which is about the values and attitudes required for professional practice (Billett 2001; Sweet & Glover 2011).

Midwifery, as a practice-based profession, requires students to gain competence in professional practice and therefore requires effective clinical education. The Australian Nursing and Midwifery Accreditation
Council (2009) has clearly stated the clinical education requirements that the midwifery student must meet, in order to gain initial registration with the Nursing and Midwifery Board of Australia.

Clinical education should not be the provision of experiences alone, as this would be insufficient for effective learning. The purpose of clinical education is to develop the required knowledges for occupational practice in the context of the real world of work (Billett 2001). A core component of the curriculum of clinical education experiences is feedback for the learning and assessment of performance. In order to attain learning in clinical environments, feedback is crucial (Van De Ridder et al. 2008). Glover (2000 p247) found that in a cohort of nursing students “feedback had the ability to enhance the student’s performance and make them feel confident and competent in their role, especially when the feedback is immediate”. Whilst assessment of learning, and in particular clinical competence, has been debated widely in the literature and is frequently presented in the schema of Millers pyramid (van der Vleuten et al. 2010) (see Figure 1). According to Miller’s pyramid (1990), the highest level of assessment of clinical practice is considered the level of “does” which realistically can only occur in the workplace in the context of the occupational practice (van der Vleuten et al. 2010).

**MiniCEX**

The miniCEX is a tool for workplace based assessment which is particularly useful because it covers many dimensions of observed performance and assesses overall competence. This can be likened to the knowledges required for professional practice. The mini CEX tools typically have check boxes to identify context, task and complexity being observed, rating scales to determine the students’ performance across the range of practice domains and sections for written feedback from both the student and the assessor. A key component of the miniCEX is the opportunity for formative assessment and feedback, as an integral component of the assessment process (Norcini 2007). Text Box 1 describes how to undertake a miniCEX assessment. The incorporated feedback session should encourage the student’s self-assessment and the development of an action plan for further learning (Norcini 2007). Hill and Kendall (2007) report that students found the miniCEX increased their motivation to learn clinical skills and apply theory to practice. Furthermore, it helped them to identify their own strengths and weaknesses, and improve and enhance their clinical skills. The miniCEX is an ideal way for ongoing assessment and provision of formative feedback, and ensures that the clinical skills of students are actually observed and evaluated rather than assumed or perceived. The miniCEX is a student centred approach which encourages them to take control of the context and frequency they seeking feedback.

An integral component to the effective implementation of the miniCEX is staff development. Hill and Kendall (2007) suggest that staff who undertake observation of students for the miniCEX need very clear guidelines to ensure that there is a degree of consistency in the assessments. Indeed the establishment of performance guidelines/criterion expected of a third year medical student was a useful approach to provide guidance for assessors, and staff development in assessment and feedback at an Australian University.
METHODS

An action research approach was used to develop and implement the miniCEX assessment tool in a midwifery context. Action research is a reflective process of progressive problem solving, led by individuals working with others in teams or as part of a community of practice to improve the way they address issues and solve problems (Taylor et al. 2006). Action research is a useful approach in health settings as it can be guided by professional researchers, with the aim of improving their health professionals strategies, practices, and knowledge of the environments within which they practice (Webb 1989; Schwandt 2007). In this project, action research was used for improvement purposes (as described by Meyer 2000) to achieve consensual definitions and develop the midwifery miniCEX assessment tool using the postnatal community of midwifery clinicians as the experts, and facilitated by university researchers.

Ethical approval for the project was granted by the Southern Adelaide Health Service Human Research Ethics Committee, which is recognised also by the associated university. All participants provided informed written consent and all data was de-identified upon collection.

The project was conducted in three phases: 1) development of the midwifery miniCEX assessment tool; 2) implementation of the midwifery miniCEX assessment tool in the postnatal ward; and 3) evaluation of the midwifery miniCEX assessment tool.

Phase One

Three focus groups with experienced registered midwives and new graduate midwives were held to establish their current approaches to assessment, and explore their clinical expectations of students across the domains of midwifery practice. The focus groups were digitally recorded (LS) and transcribed verbatim by a professional secretariat company. Data were descriptive analysed with specific focus on content (Taylor et al. 2006; Saldana 2009) to (1) identify current approaches to assessment, (2) inform the adaption of the existing miniCEX assessment forms for medical students, to suit midwifery students practicing in midwifery contexts. Following the first focus group, initial draft documents were developed by the researchers and then used in the subsequent focus groups to generate further discussion as to their applicability, with further adaption and refinements made through each action cycle (Meyer 2000; Taylor et al. 2006).

Phase Two

This phase involved the delivery of education sessions on 1) the use of the midwifery miniCEX and ways to give effective feedback for postnatal midwifery staff, and 2) the use of the midwifery miniCEX with current midwifery students. All registered midwives responsible for midwifery student supervision in the postnatal ward were invited to attend an education session on conducting student formative assessment and giving feedback using the midwifery miniCEX assessment form. These sessions were offered on five occasions, on varying days and times, to enable the attendance by the majority of staff midwives. Midwifery students
that were being placed on the participating postnatal ward were invited to be involved in the project, by undertaking midwifery miniCEX assessments during their clinical practice. Written informed consent was sought from the midwifery students to participate. Students were asked to identify opportunities and approach staff to undertake a miniCEX, and then provide a copy of the completed forms to the research team. The completed assessments formed data, which were descriptively analysed for consistency, completeness, time for assessment and qualitative comments (Saldana 2009).

**Phase three**

The final phase of the project was evaluation of the applicability of midwifery miniCEX from the perspective of both midwifery staff and students. This phase involved qualitative evaluation by focus group discussion and survey responses. The focus groups were digitally recorded (LS) and transcribed verbatim by a professional secretariat company. Data were then subjected to a thematic analysis (Taylor et al. 2006; Saldana 2009). Qualitative research is the most suitable method to explore the perceptions and experiences of participants of this novel approach to midwifery assessment and feedback, to generate sufficient depth of knowledge and understanding. The computer software program—NVivo 9—was used to assist in the data management and qualitative analysis processes.

**Findings**

The aim of this research was to develop, implement and evaluate a miniCEX tool for midwifery education. Given the many action cycles that occurred, the findings from this study are now presented in 5 areas, demonstrating 1) the midwives’ current approaches to assessment and 2) the barriers they identified to assess and give feedback to students. These aspects guided the 3) development of the miniCEX tool which is described, followed by 4) the education sessions provided and the implementation of the assessment tool. The final findings presented demonstrate the 5) evaluation of the miniCEX assessment tool for midwifery education.

**Midwives approach to assessment**

The first phase of the study was the examination of the midwives approach to assessment, barriers and issues they face during workplace-based assessment and feedback of midwifery students prior to the development and implementation of the miniCEX. Two focus groups were held with midwives of varying experiences from new graduates to those with more than 20 years of midwifery practice; a total of 14 midwives participated in this phase. Data analysis identified that the midwives do assess all of the required knowledges for professional practice (conceptual, dispositional and procedural), but in doing so, face many barriers in the current processes stemming from both the health service and the university. Whilst they review the student across the breadth of knowledges for professional practice, these are not well presented on the current assessment documentation that is returned to the University.
There was evidence that midwives focused heavily on dispositional knowledge of the midwifery student. The types of dispositions they looked for in the midwifery student were their attitude, confidence, honesty, self-initiative, interest in midwifery practice and in learning, and awareness of self-limitations. These values and attitudes were strongly presented as the primary aspect of the assessment in the workplace. The midwives frequently made comments such as:

“I like to see them taking initiative”

“I look at the way they interact with the woman. Their manner, their body language, friendliness, approachability”

Furthermore, the midwifery student’s interpersonal skills including their ability to develop rapport with women, their ability to relate to the women, participation in teamwork and communication were all highly valued and underpinned the approach to assessment.

The next major area that midwives discussed as important in their approach to assessment was conceptual knowledge. For this aspect of assessment, the midwives made attempts to ascertain if the student was aware why they were doing the things they were doing, as opposed to just performing the tasks. The ability to provide a rationale for practice and furthermore, anticipate what may be required or occur in the context of practice was highly valued in the student. In order to assess conceptual knowledge, the midwives would question the student, and provide advice and guidance if they felt it necessary. Midwives describe this as:

“Normally I’d just ask them whether they know what they’re doing, maybe what’s going on before we go to the patient.” …

“Have you done this before; do you know why we do this? All that kind of stuff. I usually do that before we go in the room so that I’m prepared”

Whilst the midwives strongly focused on dispositional and conceptual knowledge in the workplace based assessment, they said that procedural knowledge was vital to clinical competence. This presented in the focus groups as a taken for granted component of assessment and feedback. Clinical skills appropriate for the year level were integral to practice, and the midwives assessed these observations of practice. One midwife described:

“You’re observing what they’re doing, how they’re talking to the women, their actual clinical skills that they’re performing. That’s the main thing I suppose, observing.”

And another midwife said they observe to:

“Seeing that whether they’re following the protocol and things.”

Other procedural knowledges that were deemed important by the midwives were time management, organisation, and preparation, and accurate and timely documentation.

**Midwives’ barriers to assessment and feedback**

When discussing the ways in which they undertook assessment of the midwifery students in the workplace, the midwives became very vocal on discussing barriers to their ability to assess and give effective
feedback. These barriers can be described as related to both the health service culture and the University requirements. The midwives expressed great concern in the lack of continuity between midwives and students which negatively impacted on their ability to make a fair and just assessment of the student’s performance. For example:

“you might’ve had this shift with a student and it hasn’t been great. You read all these reports and they’re all, ‘worked independently’ and I was thinking, well that’s not the student that I saw.”

This lack of continuity contributes to the provision of vague general comments and a compassionate approach to the learner. The midwives did not want to dishearten or write negative feedback even when it may have been appropriate, and this was a cause of angst for the midwives. As two midwives explained:

“you don’t want to rate them too low on their first placement because you don’t want to knock them down before they’ve even started”

“If I’ve got someone that I’m a bit worried about I don’t write terrible things on their feedback. I say, you might need to focus on such and such next time you come, to try and improve on that.”

As shown in the above quotes, the midwives would write general comments on the assessment form, however provide more constructive feedback for learning verbally to the student. This creates significant issues from both the health service and the University perspectives as fair and just assessment of the midwifery student performance is not being shared appropriately. Whilst there is evidence the midwives assess the knowledge required for professional practice, these are rarely documented as evidence of the students’ competence.

The manner in which midwives were asked to document their assessment of the student and provide feedback was considered problematic. The participating university require a daily feedback comment be obtained by the student from the midwife they worked with. These are gathered, and a collated competence form completed usually by the most senior midwife in the clinical area, at the end of the semester. Midwives identified a lack of consistency in approach to assessment and feedback from individual midwives within the unit and also from the student’s requirements from their respective universities. As students are required by the participating University to seek written feedback on a daily basis, the timing at which this is sought often results in brief and ineffective assessment and feedback. One midwife explained:

“I hate those feedback forms. They stand over you whilst you write them. I just want to say something nice because it’s probably been an awful day and you just got through it as best you can”

The culture of a student presenting a feedback form to a midwife at the end of a shift was also seen as highly problematic. As described by another midwife:

“Most of us are not very happy when we’re given an assessments sheet at 25 past 3.00pm [end of shift]”

This type of documentation of assessment and feedback on a daily basis leads to difficulties with senior staff assessing a student’s individual competence to practice. A senior midwife explained:

“When I have to write a report on them, I find it really difficult to write when someone just says ‘good midwife’ or ‘good student’, ‘a pleasure to work with’ - it doesn't give me the things whereas
I'm looking for specific things like the Guthrie they did well, they didn't do well. Do you know - specific things..."

Overall, these focus groups highlighted many aspects of the current approach to assessment and feedback as being ineffective and unsatisfactory for the midwives, the University, and the individual midwifery student. The midwives eagerly participated in the development of the miniCEX tool as they saw great benefit in its application for them and the learner. Through the focus groups midwives expressed great positive anticipations of the miniCEX as an improvement from the current practices. Such comments from the many midwives included:

“It will be heaps quicker and more specific” … “I like this because it is so specific to certain parts of communication” “I think this is really quite good for midwives to look at their own practice. I think there’s a lot here and to maybe look at the students in a little bit more developmental manner” … “It’s giving you direct things to focus on. The well done, the what can be improved and what’s the student agreed to do about improving their learning.”

**Development of the miniCEX**

In order to develop the midwifery miniCEX the researchers reviewed the literature and gathered many examples of tools in use in both medicine and nursing. These were reviewed and presented throughout the focus groups, and agreement established as to the format and content of the midwifery miniCEX. The midwifery miniCEX was developed using language commensurate with a woman centred wellness philosophy (ANMAC 2009), in keeping with midwifery practice. The developed midwifery miniCEX is shown as Figure 2. In line with published recommendations for implementation of the miniCEX (Norcini 2005; Hill & Kendall 2007; Norcini 2007) instructions were included on the back of the form (shown in Box 1) along with space for student comments and reflection. During education sessions and within the instructions (see Box 1) the researchers recommended the use of Pendleton's rules (Cantillon & Sargeant 2008) for feedback, as they promote learner self-reflection, are brief and easy to remember. Throughout the education sessions, midwives practiced these techniques and gave positive affirmations of their usefulness for practice.

**Implementation of the miniCEX**

Second and third year midwifery students placed on the postnatal ward were invited to participate in the study through seeking miniCEX assessments during their clinical placement. Midwifery staff were also encouraged to promote the miniCEX with the students, and to actively engage in the project. The implementation occurred across the 12 week University semester in 2011. Fifteen midwifery students undertook clinical placement on the participating postnatal ward during this time and thirteen consented to and participated in the miniCEX project. Over forty assessment forms were submitted to the research team, however it is known that many more were completed by the students and midwives as the students are continuing to submit these to the research team still.
All of the submitted forms provided some degree of performance rating across some or all of the Australian Midwifery domains of practice (ANMC2009), and included written feedback in relation to what was done well and what could be improved, however not all submitted forms included a plan for action. The majority of submitted forms had a rating provided for each domain; however for some assessors there appeared to be a tendency to rate at the “Above Expectations” across all fields. The content of the written feedback was relevant to the task observed, and was focused and specific for learning. The time to undertake the observation of practice ranged from 3 to 20 minutes and for the discussion and feedback 2 to 5 minutes, with the vast majority being 5 minutes. All other aspects of the forms were generally well completed with identifying information about the student and the assessor, the midwifery presentation and context of the interaction being observed.

**Evaluation of the miniCEX**

Evaluation to date has been undertaken by focus group with midwifery students, and through individual discussions with midwifery staff. Further evaluation is planned in the coming months. Midwifery staff expressed enthusiasm about the tool and its potential application beyond the Bachelor of Midwifery students. They did not find it tedious or time-consuming, but more so time efficient, in that they could provide the student with some valuable and useful feedback and an assessment throughout the day when time allowed. The midwives found the planned assessment approach gave them the opportunity to provide feedback which was expected at the time by the student, and actively sought.

The midwifery students were very positive about the applicability and value of the midwifery miniCEX for enhancing their learning. Students expressed significant concern at the current approach to assessment and feedback, which confirmed much of what the midwives themselves had identified. The students described being given occasional verbal formative feedback throughout a shift by midwives, but then getting very generic written comments which were usually positive and nice, but which they called *meaningless* as they did not offer guidance for further learning. Furthermore, the students expressed great concern at the current mechanism being numbers and task focused, akin to verification of skill attempt rather than competence based, with limited encouragement for formative feedback for their learning. In relation to showing their achievements in practice, the students said:

“*They don't say anything they just sign it; say you've done it on this day; that's it.*”… “*they send you off to do a bath demo but they don't actually watch you or hear what you're doing, but you get signed off for it. They have no idea what you're telling the parents.*” … “*usually it's just signed that you did it; whether you did it well or not*”

Students who participated in the midwifery miniCEX assessments found them generally to be very rewarding and efficient. Students specifically commented on the value of the written feedback they received, as it was tangible, meaningful and specific to their own learning.

“*Because the midwife was really happy to say what I'd done wrong and where I could improve. We had agreed on an action plan on what to do.*”… “*Because it was written down and we had
areas to go by.” … “It's good for us to take away and look at it; go right, this is what I need to do next time and this is what I did differently”

Furthermore, students expressed a sense of satisfaction from the midwives with the miniCEX as it gave them guidance on what to assess, encouraged specific feedback, and could be done throughout the shift and not left to the end.

“The midwives are happier to fill these out because it's specific rather than the generalised feedback form we have at the moment.” … “Because it lists all the different areas that you have to focus on, the midwife actual thinks about them” .. “They're happy to do that straight after something and go okay, great, given you feedback; rather than at the end of the shift”.

A frequent concern was raised about the role of the assessor in the process. The midwifery miniCEX assessments which the students found to be less rewarding and valuable were ones where the assessor was described as taking over the interaction and not maintaining an observational role.

“I'd go to do the talking and writing, and she would interject and completely cut me off” … “Then, all of a sudden, they'll just take it off on a tangent and you're like ‘I was talking’.”

In response to this experience, students recommended a modification to provide a space for the student to reflect on their performance and write their own perceptions. They felt that as the midwifery miniCEX was an assessment, and the midwife was in a position of power, that as the student they would feel too intimidated to disagree at the time even if they thought the assessment was not fair.

Students expressed anxiety about the grading aspect of the assessment tool, and whilst accepting of graded assessments, recognised the difference when this is being done for high-stakes summative assessment. Students sought midwives with whom they had good rapport, as they felt their interactions with women would be different in the presence of a midwife assessing their performance. The students were confident that this anxiety would settle once the midwifery miniCEX became expected and common, in their clinical experiences.

DISCUSSION

This small project has shown the midwifery miniCEX to enhance the feedback and assessment of students in a range of clinical situations in the postnatal environment. The findings of midwives’ assessment practices from this study support those of Smith (2007); particularly in relation to the aspects of practice sought for assessment, the inexperience of clinicians in grading, grading inflation, and the social process of assessment. Throughout this action research project the midwives engaged well with the education sessions on assessment and feedback. There is evidence from the data that assessment in the workplace is a social practice, which occurs within a hierarchy, and therefore it is highly important that the assessor take an objective and observational role, rather than interactive role. Van der Vleuten et al (2010) caution over the use of individual encounter assessments as a means of summative assessment. For example they argue “If the purpose is narrowed to doing eight summative MiniCEXs, learners will start to play the game
and make their own strategic choices regarding moments of clinical skills and selection of assessors" (van der Vleuten et al. 2010 p712). These behaviours were expressed to a small degree throughout the evaluation, however the intent of the midwifery miniCEX is for formative assessment. If it is to be used for summative purposes, further examination of validity and reliability is required as well as assessor preparation and training. Smith (2007) and Van der Vleuten et al (2010) recommend a multi-methods approach that foster effective learning through assessment processes and avoid bias.

As an assessment and feedback tool, the midwifery miniCEX does have some limitations. Previous research from medical education has shown that the validity and reliability of the miniCEX is dependent on number assessment instances, the variation in clinicians or faculty undertaking the assessment, and the variation in the nature of the encounters that the assessment is performed (Norcini et al. 1995; Holmboe et al. 2003; Kogan et al. 2003; Norcini 2007). Further research and evaluation on the midwifery miniCEX in diverse midwifery contexts is warranted. Furthermore, detailed investigation of reliability and validity of the midwifery miniCEX and assessor performance is also required.

Useful tips on implementing the miniCEX as a tool for direct observation of clinical practice has been published (Hauer et al. 2011). Amongst these 12 tips, staff development to ensure consistency in performance rating, provision of meaningful feedback, and collaboratively development of action plans for learning are advocated (Hauer et al. 2011). These are all aspects which have been highlighted through this research and evaluation to date, but warrant further development.

**Limitations of the study**

This research has adapted and trialled a miniCEX for midwifery from the perspectives of midwifery students, midwifery clinicians and academic staff in Australia. The development and pilot project has occurred in one postnatal ward. There is a need to implement this assessment method across more diverse midwifery settings and further evaluate its efficacy and value for teaching and learning. Additional research is required to assess the validity and reliability of the midwifery miniCEX and how assessor bias can be minimised. Whilst developed in an Australian context, the Australian Midwifery domains of practice (ANMAC2009) which are assessed by the miniCEX would have global application as they are based on the international definition of a midwife.

**CONCLUSION**

Effective and timely assessment and feedback is essential for learning dispositional, conceptual and procedural knowledges for professional practice in midwifery. This study has adapted and trialled the miniCEX assessment tool to enhance the educational experience of midwifery students in a postnatal environment. There is no doubt that midwives in the post natal ward welcomed this new and exciting initiative. The midwives saw the potential value of the midwifery miniCEX assessment tool and actively engaged in its development, implementation, and evaluation. The midwives were able to complete the assessment and document this effectively on the forms. The midwives described their confidence in
providing a fair and justified assessment and feedback was enhanced. The midwifery students engaged positively with the midwifery miniCEX and found it significantly valuable to identify aspects of their practice for improvement and refinement. The positive response and evaluation outcomes have led to minor modifications of the original tool and the midwifery miniCEX will be implemented in the second year of a newly accredited midwifery program in Australia in 2012. With adaption to individual local contexts and competence assessment criteria, the midwifery miniCEX has a global application potential.

ACKNOWLEDGEMENT

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# Mini Clinical Evaluation Exercise (MiniCEX)

**Student name** ______________________________  **Student ID** □□□□□□□□□□

## Midwifery Presentation:

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<th>2 Borderline performance</th>
<th>3 Meets expectations</th>
<th>4-5 Above Expectations</th>
<th>N/A Not applicable – not observed</th>
</tr>
</thead>
</table>

## Feedback

What was done well?

What could be improved?

Agreed plan of action?

## Assessor’s Position

☐ Midwife  ☐ GP  ☐ Registrar  ☐ Specialist  ☐ Other

## Time taken to do MiniCEX

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td></td>
</tr>
<tr>
<td>Feedback</td>
<td></td>
</tr>
</tbody>
</table>

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**Assessor’s Signature** ______________________________

**Assessor’s Name (Print)** ______________________________

**Student’s Signature** ______________________________
Box 1

How do I do a MiniCEX?

- First, the student and clinician should discuss the last miniCEX – how it went, any areas the student wants/needs to focus on for skill development and/or feedback.
- The miniCEX should be done on routine midwifery care and be based on student-client interaction.
- The miniCEX observation should take no more than one 20 minute interaction. It may be an observation of health assessment, history taking, examination, discussion of or performance of management, or health education with women as some examples.
- Following the observed interaction the clinician and student should then spend 5-10 minutes discussing the exercise and providing feedback based on the domains of the miniCEX form and the ANMC Midwifery Competencies.
- This is a great opportunity to encourage the student to reflect on their own performance.
- Feedback should be a two way dialogue to promote self-reflection. We suggest the use of Pendleton’s rules (Cantillon and Sargeant 2008) which follow the format of: briefly ask the student how they felt the interaction went; provide constructive critique of well-done behaviours. Then ask the student what areas they recognise/feel they are able to or need to improve on, and if you agree, confirm these. If you recognise others – suggest one or two areas for improvement. Agree on a plan of learning for improvement. Note these on the miniCEX form.
- You may negotiate a follow up plan to undertake practice and another miniCEX assessment.

Reference
Figure 1: Millers Pyramid (Miller 1990)

Reference: