Mini Clinical Examination Assessment (Mini-cex)

The following provides structure to have a consultation with a patient assessed. An anonymised copy of the patient record which has been authenticated by the assessor or senior member of the team should be attached. Please note that the portfolio should include evidence of development, so being assessed as '*further development required*' has relevance and a place in the portfolio.

Trainee Name & Qualification	

Case details: presenting complaint, Age & Sex	

Overall Level of Achievement	Further development required	Demonstrated Competence	Accomplished Performance

	Not yet competent	Competent	Rationale
Washes hand & dons PPE as apt			
Ability to quickly build therapeutic relationships with patient and their significant others			
Introduces self			
Good eye contact			
Speaks at a volume patient & significant other can hear			
Speaks with tone and speed that demonstrates empathetic, interested non-judgemental & respectful approach			
Explains necessary information in language that patient and significant others understand			
Checks patient's understanding			
Gives opportunity for patient and significant other to ask questions			
Interventions, Management & Planning			
Elicits a targeted structured history relevant to the presenting complaint. Includes: *PMH, DH, social history, allergies; psychological needs.*			
Considers essential care needs and attributed risks includes: *pain management, hydration; nutrition; pressure risks; hygiene, toilet needs, distracting measures; psychological needs; manual handling; infection prevention and control,*			
Identifies and records relevant vital signs & observations			
Identifies and records relevant POCT e.g. urinalysis, pregnancy test, peripheral blood sugar			

Identifies need for other interventions *e.g., venepuncture / cannulation, blood samples including gases, fluids, ECG, antibiotics.*			
Interprets, evaluates & documents findings			
Is able to prioritise care & interventions required			
Develops and implements a relevant timely therapeutic management plan that could include physical / psychological need, follow up arrangements, family considerations, discharge plans			
Overall demonstrates safe patient management			

Strong areas are:

Areas for improvement are:

General overall comment:

Confirmed copy of anonymised patient record authenticated & attached (sign)	
Assessors Name (print)	
Designation & Qualifications	
Assessor Signature & Date	
Trainees Signature & Date	