Supervised Practice Experience Partnership (SPEP) Reporting Form

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

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Instructions

1. Please save this pdf to your computer.
2. This form must be completed by the organization to report issues or concerns about an applicant's practice or conduct while participating in SPEP.
3. Please complete this form and email it to spe@cnomail.org along with the completed SPEP Assessment Form for Preceptors (or your organization's equivalent). For the forms to be accepted, all fields must be answered. Incomplete forms may cause delays in the process.
4. CNO staff may follow-up with the organization for clarification and/or additional details.

Please review CNO's *Privacy Policy* to understand how your personal information will be used.

SECTION 1 — APPLICANT INFORMATION

First name of applicant

Email address of applicant

Last name of applicant

Application Number

SECTION 2 — ORGANIZATION INFORMATION

Name of organization

Telephone number (including area code)

Street address

City

Postal code

Primary contact first name and last name

Primary contact email address

Secondary contact first name and last name

Secondary contact email address

APPLICANT SUPERVISED PRACTICE EXPERIENCE

Start date of SPEP program (DD/MM/YYYY)

End date of SPEP program (DD/MM/YYYY)

Total number of hours completed: _____

Category of SPEP practice:

☑ Registered Nurse (RN)

☐ Registered Practical Nurse (RPN)

Please complete page 2-3 and attach the SPEP Assessment Form for Preceptors (or your organization's equivalent)

What is the nature of your practice or conduct concerns (choose all that apply):

Competency issues:

- ☐ Clinical decision-making
- ☐ Nursing process (treatment/intervention/monitoring evaluation)
- ☐ Assessment
- ☐ Medication administration
- ☐ Documentation
- ☐ Comprehension of instructions
- ☐ Other

Communication abilities:

- ☐ Reading
- ☐ Writing
- ☐ Listening
- ☐ Speaking

Conduct concerns:

- ☐ Professionalism
- ☐ Attendance
- ☐ Interpersonal relationships
- ☐ Medication diversion
- ☐ Harassment
- ☐ Ethics
- ☐ Patient Abandonment/Transfer of accountability
- ☐ Boundary violation
- ☐ Other

INCIDENT/EVENT OF CONCERN

Please summarize your concerns or the event(s) or incident(s) that occurred during the SPEP placement. If you require more space for your answers or for additional incident/event reports, please attach additional pages as needed.

_____

Date of occurrence

Incident/Event:

Consequences to client/others:

SPEP applicant response/explanation:

Organization action/Remedial activities taken:

Other comments:

I hereby certify that the information provided is accurate and complete.

Primary or secondary contact name

Signature

Date (DD/MM/YYYY)