



Indiana State Board of Nursing  
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Governor Mitchell E. Daniels, Jr.

### ANNUAL REPORT FOR PROGRAMS IN NURSING

**Guidelines:** An Annual Report, prepared and submitted by the faculty of the school of nursing, will provide the Indiana State Board of Nursing with a clear picture of how the nursing program is currently operating and its compliance with the regulations governing the professional and/or practical nurse education program(s) in the State of Indiana. The Annual Report is intended to inform the Education Subcommittee and the Indiana State Board of Nursing of program operations during the academic reporting year. This information will be posted on the Board's website and will be available for public viewing.

**Purpose:** To provide a mechanism to provide consumers with information regarding nursing programs in Indiana and monitor complaints essential to the maintenance of a quality nursing education program.

**Directions:** To complete the Annual Report form attached, use data from your academic reporting year unless otherwise indicated. An example of an academic reporting year may be: August 1, 2011 through July 31, 2012. Academic reporting years may vary among institutions based on a number of factors including budget year, type of program delivery system, etc. Once your program specifies its academic reporting year, the program must utilize this same date range for each consecutive academic reporting year to insure no gaps in reporting. You must complete a **SEPARATE report** for each PN, ASN and BSN program.

This form is due to the Indiana Professional Licensing Agency by the close of business on October 1st each year. The form must be electronically submitted with the original signature of the Dean or Director to: [PLA2@PLA.IN.GOV](mailto:PLA2@PLA.IN.GOV). Please place in the subject line "Annual Report (Insert School Name) (Insert Type of Program) (Insert Academic Reporting Year). For example, "Annual Report ABC School of Nursing ASN Program 2011." The Board may also request your most recent school catalog, student handbook, nursing school brochures or other documentation as it sees fit. It is the program's responsibility to keep these documents on file and to provide them to the Board in a timely manner if requested.

Indicate Type of Nursing Program for this Report: PN \_\_\_\_\_ ASN X BSN \_\_\_\_\_

Dates of Academic Reporting Year: 07/01/2012 to 06/30/2013  
(Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: Breckinridge School of Nursing and Health Sciences @ ITT Technical Institute

Address: 17390 Dugdale Drive, Suite 100  
South Bend, Indiana 46635

Dean/Director of Nursing Program

Name and Credentials: Debra Horoho RN, PhD

Title: Program Chair, Nursing Email: DHoroho@itt-tech.edu

Nursing Program Phone #: 574-247-8300 Fax: 574-247-8350

Website Address: www.itt-tech.edu

Social Media Information Specific to the SON Program (Twitter, Facebook, etc.): http://twitter.com/itttech  
http://www.facebook.com/ITTTech?fref=ts, http://www.youtube.com/user/itttech?feature=results\_main

Please indicate last date of NLNAC or CCNE accreditation visit, if applicable, and attach the outcome and findings of the visit: N/A

If you are not accredited by NLNAC or CCNE where are you at in the process? Waiting for final visit approval from Indiana State Board

**SECTION 1: ADMINISTRATION**

Using an "X" indicate whether you have made any of the following changes during the preceding academic year. For all "yes" responses you must attach an explanation or description.

- 1) Change in ownership, legal status or form of control Yes \_\_\_\_\_ No X
- 2) Change in mission or program objectives Yes \_\_\_\_\_ No X
- 3) Change in credentials of Dean or Director Yes \_\_\_\_\_ No X
- 4) Change in Dean or Director Yes \_\_\_\_\_ No X
- 5) Change in the responsibilities of Dean or Director Yes \_\_\_\_\_ No X
- 6) Change in program resources/facilities Yes \_\_\_\_\_ No X
- 7) Does the program have adequate library resources? Yes X No \_\_\_\_\_
- 8) Change in clinical facilities or agencies used (list both additions and deletions on attachment) Yes X No \_\_\_\_\_
- 9) Major changes in curriculum (list if positive response) Yes X No \_\_\_\_\_

**SECTION 2: PROGRAM**

1A.) How would you characterize your program's performance on the NCLEX for the most recent academic year as compared to previous years? Increasing X Stable \_\_\_\_\_ Declining \_\_\_\_\_

1B.) If you identified your performance as declining, what steps is the program taking to address this issue?

\_\_\_\_\_

2A.) Do you require students to pass a standardized comprehensive exam before taking the NCLEX?  
Yes  No

2B.) If **not**, explain how you assess student readiness for the NCLEX. \_\_\_\_\_

\_\_\_\_\_

2C.) If **so**, which exam(s) do you require?  
HESI RN Exit Exam \_\_\_\_\_

2D.) When in the program are comprehensive exams taken: Upon Completion   
As part of a course  Ties to progression or thru curriculum \_\_\_\_\_

2E.) If taken as part of a course, please identify course(s): NU120 Clinical Nursing Concepts & Techniques I

3.) Describe any challenges/parameters on the capacity of your program below:

A. Faculty recruitment/retention: \_\_\_\_\_

\_\_\_\_\_

B. Availability of clinical placements: \_\_\_\_\_

\_\_\_\_\_

C. Other programmatic concerns (library resources, skills lab, sim lab, etc.): \_\_\_\_\_

\_\_\_\_\_

4.) At what point does your program conduct a criminal background check on students?  
CBC is completed on students during their third quarter before they start clinical in their fourth quarter.

5.) At what point and in what manner are students apprised of the criminal background check for your program? Students are apprised of the CBC during the application process with the Representative using

### **SECTION 3: STUDENT INFORMATION**

1.) Total number of students admitted in academic reporting year:

Summer Jun 2013 - 16 Fall Sep 2012 - 26 Spring Mar 2013 - 24 Winter Dec 2012 - 17

2.) Total number of graduates in academic reporting year:

Summer Jun 2013 - 9 Fall Sep 2012 - 12 Spring Mar 2013 - 15 Winter Dec 2012 - 22

3.) Please attach a brief description of all complaints about the program, and include how they were addressed or resolved. For the purposes of illustration only, the CCNE definition of complaint is included at the end of the report.

4.) Indicate the type of program delivery system:

Semesters \_\_\_\_\_ Quarters  Other (specify): \_\_\_\_\_

**SECTION 4: FACULTY INFORMATION**

A. Provide the following information for **all faculty new** to your program in the academic reporting year (attach additional pages if necessary):

<b>Faculty Name:</b>	
<b>Indiana License Number:</b>	
<b>Full or Part Time:</b>	
<b>Date of Appointment:</b>	
<b>Highest Degree:</b>	
<b>Responsibilities:</b>	

<b>Faculty Name:</b>	
<b>Indiana License Number:</b>	
<b>Full or Part Time:</b>	
<b>Date of Appointment:</b>	
<b>Highest Degree:</b>	
<b>Responsibilities:</b>	

<b>Faculty Name:</b>	
<b>Indiana License Number:</b>	
<b>Full or Part Time:</b>	
<b>Date of Appointment:</b>	

<b>Highest Degree:</b>	
<b>Responsibilities:</b>	

B. Total faculty teaching in your program in the academic reporting year:

1. Number of full time faculty: <sup>8</sup>\_\_\_\_\_
2. Number of part time faculty: <sup>0</sup>\_\_\_\_\_
3. Number of full time clinical faculty: <sup>0</sup>\_\_\_\_\_
4. Number of part time clinical faculty: <sup>0</sup>\_\_\_\_\_
5. Number of adjunct faculty: <sup>1</sup>\_\_\_\_\_

C. Faculty education, by highest degree only:

1. Number with an earned doctoral degree: <sup>1</sup>\_\_\_\_\_
2. Number with master's degree in nursing: <sup>8</sup>\_\_\_\_\_
3. Number with baccalaureate degree in nursing: <sup>0</sup>\_\_\_\_\_
4. Other credential(s). Please specify type and number: <sup>0</sup>\_\_\_\_\_

D. Given this information, does your program meet the criteria outlined in **848 IAC 1-2-13**?

Yes  No

E. Please attach the following documents to the Annual Report in compliance with **848 IAC 1-2-23**:

1. A list of faculty no longer employed by the institution since the last Annual Report;
2. An organizational chart for the nursing program and the parent institution.

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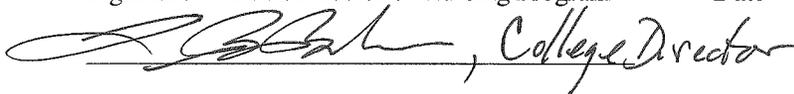
I hereby attest that the information given in this Annual Report is true and complete to the best of my knowledge. This form **must** be signed by the Dean or Director. No stamps or delegation of signature will be accepted.

Debra Horoho RN, PhD

 8-21-13

Signature of Dean/Director of Nursing Program

Date

, College Director 8/21/13

Printed Name of Dean/Director of Nursing Program

Please note: Your comments and suggestions are welcomed by the Board. Please feel free to attach these to your report.

Definitions from CCNE:

**Potential Complainants**

A complaint regarding an accredited program may be submitted by any individual who is directly affected by the actions or policies of the program. This may include students, faculty, staff, administrators, nurses, patients, employees, or the public.

**Guidelines for the Complainant**

The CCNE Board considers formal requests for implementation of the complaint process provided that the complainant: a) illustrates the full nature of the complaint in writing, describing how CCNE standards or procedures have been violated, and b) indicates his/her willingness to allow CCNE to notify the program and the parent institution of the exact nature of the complaint, including the identity of the originator of the complaint.

The Board may take whatever action it deems appropriate regarding verbal complaints, complaints that are submitted anonymously, or complaints in which the complainant has not given consent to being identified.

Faculty that are no longer teaching

Faculty Name: Rachel Moyer

Indiana License Number: 28153710A

Full or Part Time: Part time (2 quarters)

Date of Appointment: 12/5/2011

Highest Degree: BSN

Responsibilities: OB Clinical only

Faculty Name: Laura Lauderman

Indiana License Number:

Full or Part Time: Part time (2 quarters)

Date of Appointment: 12/5/2011

Highest Degree: BSN

Responsibilities: OB Clinical only

Faculty Name: Southworth, Elisabeth

Indiana License Number:

Full or Part Time: Part time (2 quarters)

Date of Appointment: 4/02/12

Highest Degree: BSN

Responsibilities: Mental Health Clinical only

Faculty Name: Mary Morales

Indiana License Number:

Full or Part Time: Full time (moved to Florida)

Date of Appointment:

Highest Degree: MSN

Responsibilities: Mental Health / Leadership

Section 1 Administrative YES's

Question 7 Does the program have adequate library resources

We continue to add resources each quarter in the area of NCLEX prep and subject related to nursing. Faculty review and make suggestion of new material at least one a year

Question 8 Changes in Clinical facilities or agencies (list both additions and deletions.

We added Rivercrest for Med/Surg 1 (nu2530). At the present we are not using Memorial but still have a contract with them. We are looking at several others locations to add because a clinical component has been added to Clinical Nursing Concepts and Techniques II (NU 1421) in the new revision of the program.

Question 9 Major changes in curriculum

This change has already gone through the Indiana State Board. We are changing the nursing program from 4.0 to 4.5. This increases the number of hour in the sciences and nursing classes throughout the program and added clinical time to NU1421 and NU2899 (Capstone). The didactic is increased in NU2740 and NU2745 from 1.5 hours to 3 hours.