



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. 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: July 1, 2011-June 30, 2012
(Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: Breckinridge School of Nursing at ITT-Tech

Address: 17390 Dugdale Drive Suite 100

Dean/Director of Nursing Program

Name and Credentials: Debra Horoho RN PhD

Title: Program Chair Email: dhoroho@itt.tech.edu

Nursing Program Phone #: (574) 247-8349 Fax: (574) 247-8350

Website Address: www.itt-tech.edu

Social Media Information Specific to the SON Program (Twitter, Facebook, etc.): _____

none

Please indicate last date of NLNAC or CCNE accreditation visit, if applicable, and attach the outcome and findings of the visit: None

If you are not accredited by NLNAC or CCNE where are you at in the process? Still in the initial State Board process, need final approval after 2-3 graduation classes and their board results

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 <u>X</u> |
| 2) Change in mission or program objectives | Yes _____ No <u>X</u> |
| 3) Change in credentials of Dean or Director | Yes _____ No <u>X</u> |
| 4) Change in Dean or Director | Yes _____ No <u>X</u> |
| 5) Change in the responsibilities of Dean or Director | Yes _____ No <u>X</u> |
| 6) Change in program resources/facilities | Yes _____ No <u>X</u> |
| 7) Does the program have adequate library resources? | Yes <u>X</u> No _____ |
| 8) Change in clinical facilities or agencies used (list both additions and deletions on attachment) | Yes _____ No <u>X</u> |
| 9) Major changes in curriculum (list if positive response) | Yes _____ No <u>X</u> |

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 _____ Stable X Declining _____
have only had two graduating classes (6 and 17 students) totaling 24 students

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 Exit Exam, also testing ATI at present

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): course HESI given throughout and counts as 10% of grade; Exit HESI last quarter not part of grade _____

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

A. Faculty recruitment/retention: We had several quarter where faculty was a problem but we have a full complement with all courses covered with faculty working at low full time load ratio 1:20 students

B. Availability of clinical placements: We have clinical at varies location including St. Joseph, Memorial, Holy Cross and Michiana Behavior Health Center, but continue to look for other location to broaden the experience for the student

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?
We explain the requirement before student start the program but the check is done in the third quarter (this is the quarter before clinical start)

5.) At what point and in what manner are students apprised of the criminal background check for your program? Program chair notifies student within one week of obtaining background results and follows procedure in catalog

SECTION 3: STUDENT INFORMATION

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

Summer June-(20) _____ Fall September- (30): December-(24) Spring March-(23) _____

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

Summer June-(17) _____ Fall none _____ Spring March-6 _____

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):

Faculty Name:	Newton, Lynda M
Indiana License Number:	28183182A
Full or Part Time:	full time
Date of Appointment:	10/24/2011
Highest Degree:	MSN
Responsibilities:	teaching gerontology theory and clinical, Complex care clinical

Faculty Name:	Southworth, Elisabeth
Indiana License Number:	
Full or Part Time:	Part time 2 quarters (March and June)
Date of Appointment:	4/2/12
Highest Degree:	BSN
Responsibilities:	Mental health clinical

Faculty Name:	CYNTHIA NAN Bieber
Indiana License Number:	28077836A
Full or Part Time:	Full time
Date of Appointment:	5/16/2012

Highest Degree:	MSN
Responsibilities:	teaching medical/surgical, theory and clinical

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

1. Number of full time faculty: 8
2. Number of part time faculty: 0
3. Number of full time clinical faculty: 0
4. Number of part time clinical faculty: 0
5. Number of adjunct faculty: 0

C. Faculty education, by highest degree only:

1. Number with an earned doctoral degree: 1
2. Number with master's degree in nursing: 8
3. Number with baccalaureate degree in nursing: 3 (for two quarter clinical site only) 0 now
4. Other credential(s). Please specify type and number: 0

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.

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

9-8-12

Signature of Dean/Director of Nursing Program

Date

Debra Horoho

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.