



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: 07/01/2011- 06/30/2012  
(Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: Breckinridge School of Nursing at ITT Technical Institute

Address: 10999 Stahl Rd Newburgh, IN 47630

Dean/Director of Nursing Program

Name and Credentials: Sarah A. Seaton, MSN, RN

Title: Chair Email: sseaton2@itt-tech.edu

Nursing Program Phone #: (812) 858-2349 Fax: (812) 858- 0587

Website Address: \_\_\_\_\_

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

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? \_\_\_\_\_

### 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 <u>X</u> No _____ |
| 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 <u>X</u> No _____ |
| 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 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, NU205, NU230, NU240, NU250, NU260

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

A. Faculty recruitment/retention: We have attained and maintained full faculty as described in our implementation guide. 100% of faculty are MSN prepared.

B. Availability of clinical placements: We have enjoyed adequate clinical placement and have been able to make adjustments to better meet the needs of the students because of a variety of resources from which to choose.

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?  
45-75 days prior to starting clinical rotations

\_\_\_\_\_

5.) At what point and in what manner are students apprised of the criminal background check for your program? Both during the information session before the student tests for admission, and during the New Student Orientation when they sign the "Form of Release for Background Check"

### SECTION 3: STUDENT INFORMATION

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

Summer (June) 15 Fall (Sept/Dec) 40 Spring (March) 14

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

Summer (June) 9 Fall (Sept/Dec) 40 Spring (March) 9

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): \_\_\_\_\_

<b>SECTION 4: FACULTY INFORMATION</b>
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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>	Seleta Marie Beard
<b>Indiana License Number:</b>	28176471A
<b>Full or Part Time:</b>	Fulltime
<b>Date of Appointment:</b>	09/19/2011
<b>Highest Degree:</b>	MSN
<b>Responsibilities:</b>	Clinical and Course instruction

<b>Faculty Name:</b>	Olivia Taylor
<b>Indiana License Number:</b>	28168363A
<b>Full or Part Time:</b>	Fulltime
<b>Date of Appointment:</b>	12/05/2011
<b>Highest Degree:</b>	MSN
<b>Responsibilities:</b>	Clinical and Course instruction

<b>Faculty Name:</b>	Annette Buse
<b>Indiana License Number:</b>	28125525A
<b>Full or Part Time:</b>	Fulltime
<b>Date of Appointment:</b>	01/09/2012

<b>Highest Degree:</b>	MSN
<b>Responsibilities:</b>	Clinical and Course instruction

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: 2
3. Number of full time clinical faculty: 8- share course/ clinical instruction
4. Number of part time clinical faculty: 2
5. Number of adjunct faculty: 2

C. Faculty education, by highest degree only:

1. Number with an earned doctoral degree: 0
2. Number with master's degree in nursing: 10
3. Number with baccalaureate degree in nursing: 0
4. Other credential(s). Please specify type and number: \_\_\_\_\_

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.

Sarah A Seaton MSN, RN

9/12/2012

Signature of Dean/Director of Nursing Program

Date

Sarah A Seaton

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.