**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, 2013 through July 31, 2014. 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 2013.” 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: August 1, 2013 to July 31, 2014\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: \_\_\_\_\_\_\_\_\_\_\_\_\_University of Saint Francis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_12800 Mississippi Parkway, Pavilion U, Crown Point, IN 46307\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dean/Director of Nursing Program

Name and Credentials: Margaret DeYoung, RN, MS, CNS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_Nursing Program Director\_\_\_\_\_\_ Email: mdeyoung@sf.edu\_\_\_\_\_\_\_\_\_\_

Nursing Program Phone #:\_\_\_219-488-8888\_\_\_\_\_Fax:\_\_\_\_\_\_\_219-488-8889\_\_\_\_\_\_\_\_\_\_

Website Address:\_\_\_\_\_\_\_\_www.sf.edu/crownpoint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: October 2, 2012 ACEN continuing accreditation with follow-up report due Feb 1, 2015; Accreditation letter attached below



If you are not accredited by NLNAC or CCNE where are you at in the process? N/A

**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 Yes \_\_\_\_\_ No \_ X

additions and deletions on attachment)

9) Major changes in curriculum (list if positive response) Yes\_\_\_\_\_ No \_X

**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 \_\_\_\_\_\_\_\_ Declining \_\_\_X\_\_\_

**5 year pass rate: 2009= 100%; 2010= 100%; 2011= 85.71%; 2012= 83.3%; 2013= 70.8%**

1B.) If you identified your performance as declining, what steps is the program taking to address this issue? \_\_\_NCLEX improvement plan attached: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

2B.) If **not**, explain how you assess student readiness for the NCLEX. N/A

*Must take a test but do not have to pass to graduate. ATI Comprehensive Predictor passed with 82% chance of passing NCLEX on 2 attempts. See next...*

2C.) If **so,** which exam(s) do you require? 2C.) If **so,** which exam(s) do you require? ATI Comprehensive Predictor, with a score of 82%, then successful completion of Virtual ATI or NCLEX review course if cut score not met

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

2E.) If taken as part of a course, please identify course(s): Comprehensive final exam taken in each NURS didactic course**;** Final comprehensive exam inCritical Thinking Seminar – NURS 292 \_\_

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

A. Faculty recruitment/retention: *2.5 faculty FTE’s open for fall 2014 due to one faculty retirement, one faculty resignation, 2015 and movement of .5 Sim Lab/Nursing Resource Director to administrative position.* [Note: these positions were filled for the start of fall 2014 academic year.]

B. Availability of clinical placements: None.

C. Other programmatic concerns (library resources, skills lab, sim lab, etc.): None

4.) At what point does your program conduct a criminal background check on students? Prior to first clinical experience and annually thereafter while enrolled in the program.

5.) At what point and in what manner are students apprised of the criminal background check for your program? Students are apprised when receiving clinical requirements (annually).

**SECTION 3: STUDENT INFORMATION**

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

Summer 2014\_\_\_\_\_\_\_4 Fall 2013\_\_\_\_\_\_27 Spring 2014 \_\_\_\_\_\_\_\_\_\_\_12

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

Summer 2014\_\_\_\_\_\_0 Fall 2013\_\_\_\_\_\_20 Spring 2014 \_\_\_\_\_\_\_\_\_27

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. Record of formal complaints from 8/1/13-7/31/14 attached below.



4.) Indicate the type of program delivery system:

Semesters\_\_\_X\_\_\_\_\_\_ 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:** | Susan Corbett |
| **Indiana License Number:** | 28062899A |
| **Full or Part Time:** | Full Time |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Master of Science in Nursing Education |
| **Responsibilities:** | Medical-Surgical I Nursing Theory and Clinical |

|  |  |
| --- | --- |
| **Faculty Name:** | Marianne Harman |
| **Indiana License Number:** | 28083818A |
| **Full or Part Time:** | Full Time |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Post-Masters Family Nurse Practitioner Certificate  Masters of Science in Nursing Education |
| **Responsibilities:** | Medical-Surgical Nursing II Theory and Clinical |

|  |  |
| --- | --- |
| **Faculty Name:** | Sandra Hillegonds |
| **Indiana License Number:** | 28158513A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Master of Science in Nursing - May 2014 |
| **Responsibilities:** | Clinical: Medical-Surgical Nursing III |

|  |  |
| --- | --- |
| **Faculty Name:** | Evelyn Humpfer |
| **Indiana License Number:** | 28130401A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Master of Science in Nursing |
| **Responsibilities:** | Clinical: Maternity Nursing |

|  |  |
| --- | --- |
| **Faculty Name:** | Angela Powell |
| **Indiana License Number:** | 28169927A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Master of Science in Nursing |
| **Responsibilities:** | Clinical: Medical-Surgical Nursing I |

|  |  |
| --- | --- |
| **Faculty Name:** | Sandra Sanchez |
| **Indiana License Number:** | 28108263A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Master of Science in Nursing |
| **Responsibilities:** | Clinical: Medical-Surgical Nursing III |

|  |  |
| --- | --- |
| **Faculty Name:** | Michelle Wathier |
| **Indiana License Number:** | 28167408A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | August 2013 |
| **Highest Degree:** | Master of Science in Nursing - May 2014 |
| **Responsibilities:** | Clinical: Medical-Surgical Nursing III |

|  |  |
| --- | --- |
| **Faculty Name:** | Alina Schneider |
| **Indiana License Number:** | 28188557A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | January 2014 |
| **Highest Degree:** | Master of Science in Nursing – Family Nurse Practitioner-BC |
| **Responsibilities:** | Clinical: Medical-Surgical Nursing I |

|  |  |
| --- | --- |
| **Faculty Name:** | Lisa Young |
| **Indiana License Number:** | 28100245A |
| **Full or Part Time:** | Adjunct |
| **Date of Appointment:** | January 2014 |
| **Highest Degree:** | Bachelor of Science in Nursing MSN pending 12/2014 |
| **Responsibilities:** | Nursing Resource Center Assistant |

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

1. Number of full time faculty:\_\_\_\_\_\_\_\_\_\_\_7 plus Nursing Program Director\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Number of part time faculty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_0\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Number of full time clinical faculty:\_\_\_\_\_\_\_\_\_0 if only teaching clinical\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Number of part time clinical faculty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_1 Half time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Number of adjunct faculty:\_\_\_\_\_\_\_\_\_\_\_15\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C. Faculty education, by highest degree only:

1. Number with an earned doctoral degree:\_\_\_\_\_\_\_\_\_1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Number with master’s degree in nursing:\_\_\_\_\_\_\_\_\_19\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Number with baccalaureate degree in nursing:\_\_\_\_\_\_\_\_\_3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 or 848 IAC 1-2-14**?

Yes\_\_\_X\_\_\_\_\_\_ 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

Susan Corbett: November 2013 – Resigned after semester of LOA

Cynthia Fodness July 2014 – retired July 2014

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.



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_August 27, 2014\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Dean/Director of Nursing Program Date

\_\_\_\_\_\_\_Margaret DeYoung\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ August 27, 2014\_\_\_\_\_\_\_

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.