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PLA
Professional Licensing Agency

Indiana State Board of Nursing

402 West Washington Street, Room W072

Indianapolis, Indiana 46204

Telephone: (317) 234-2043 Fax: (317) 233-4236

Website: www.PLA.IN.gov Email: pla2@pla.in.gov

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__x__ ASN_____ BSN_____

Dates of Academic Reporting Year: July 29, 2013-July 29, 2014
(Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: V.R.Ashwood Training Institute

Address: 5518 Calumet Ave
Hammond, Indiana 46320

Dean/Director of Nursing Program

Name and Credentials: Nellie A. Smith RN, MSN, EeD

Title: CEO Email; Colnet64@sbcglobal.net

Nursing Program Phone #: 1-219-803-0075 Fax: 1-219-803-0502

Website Address: www.vrat-institute.net

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

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

If you are not accredited by NLNAC or CCNE where are you at in the process? Process is not yet started

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 __X__ No _____
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_____ 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 _____NA

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

First graduating Class is schedule for October 25, 2014

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._____

2C.) If **so,** which exam(s) do you require?
ATI exit

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

2E.) If taken as part of a course, please identify course(s):_____

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

A. Faculty recruitment/retention:_____

B. Availability of clinical placements: It has been very difficult to obtain clinical sites for the OB/PEDS Clinical Rotation.

C. Other programmatic concerns (library resources, skills lab, sim lab, etc.): Skill Lab, Sim Lab would be a positive addition to the program

4.) At what point does your program conduct a criminal background check on students?
Before the beginning of any Clinical Rotation

5.) At what point and in what manner are students apprised of the criminal background check for your program? At Admission to the school and before Clinical Rotation

SECTION 3: STUDENT INFORMATION

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

Summer 8 Fall 12 Spring 7

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

Summer --------- Fall 8 Spring ----------

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. NA

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:	Nellie A. Smith RN MSN
Indiana License Number:	041173751
Full or Part Time:	Full Time
Date of Appointment:	2008
Highest Degree:	EdD
Responsibilities:	Program Director, Clinical Instructor, Faculty Educator NCLEX Review, Review Leadership

Faculty Name:	Talma Williams
Indiana License Number:	041244579
Full or Part Time:	Part time
Date of Appointment:	March 2013
Highest Degree:	MSN
Responsibilities:	Theory Instructor, Adult Patient I & II, OB/PEDS, ATI Review

Faculty Name:	Gail Goodman- Harris
Indiana License Number:	041227792
Full or Part Time:	Part time
Date of Appointment:	April 2012

Highest Degree:	MSN
Responsibilities:	Theory Instructor, Foundation of Nursing, OB/PEDS

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

1. Number of full time faculty: 1
2. Number of part time faculty: 8
3. Number of full time clinical faculty: 1
4. Number of part time clinical faculty: 3
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: 6
3. Number with baccalaureate degree in nursing: 2
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 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; No Changes
2. An organizational chart for the nursing program and the parent institution. See attachment

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.

Nellie A. Smith _____ 9/15/14 _____

Signature of Dean/Director of Nursing Program Date

Nellie A. Smith _____

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.