



Indiana State Board of Nursing

402 West Washington Street, Room W072

Indianapolis, Indiana 46204

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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: August 1, 2011 to July 31, 2012
(Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: University of Saint Francis Crown Point

Address: 12800 Mississippi Parkway, Pavilion U, Crown Point, IN 46307

Dean/Director of Nursing Program

Name and Credentials: Margaret Stoffregen DeYoung

Title: Director of Nursing – Crown Point Email: mstoffregen@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: visit scheduled for October 3, 2012

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 _____ 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 _____

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 X

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

Must take a test but do not have to pass to graduate. ATI Comprehensive Predictor passed with an 82% chance of passing (65.2%) on two attempts. See next...

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

If fails Comprehensive Predictor, provide proof of successful completion of NCLEX review course.

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): Medical Surgical Nursing III, NURS 285

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

A. Faculty recruitment/retention: Marked difficulty recruiting MSN prepared faculty, low response rate to advertised positions.

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?

Prior to student attending first clinical.

5.) At what point and in what manner are students apprised of the criminal background check for your program?

Upon inquiry on fact sheet mailed in application packet and again at acceptance to the program in nursing acceptance letter.

SECTION 3: STUDENT INFORMATION

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

Summer 2011 _____ 12 _____ Fall 2011 _____ 32 _____ Spring 2012 _____ 19 _____

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

Summer 2011 _____ 0 _____ Fall 2011 _____ 20 _____ Spring 2012 _____ 18 _____

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. NONE

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:	Cynthia Fodness
Indiana License Number:	28123166A
Full or Part Time:	Full Time
Date of Appointment:	August 19, 2011
Highest Degree:	Master in Science – Nursing
Responsibilities:	Mental Health Nursing Theory and Clinical

Faculty Name:	Marsha King
Indiana License Number:	28060484A
Full or Part Time:	Adjunct
Date of Appointment:	January 2012
Highest Degree:	Master of Science – Nursing, Master in Business Administration
Responsibilities:	Nursing Resource Center / Simulation Lab

Faculty Name:	Janice Sandoval
Indiana License Number:	28093261A
Full or Part Time:	Half Time
Date of Appointment:	August 17, 2011

Highest Degree:	Bachelor of Science – Nursing , M.P.A. Health Administration
Responsibilities:	Director of Nursing Resource Center & Simulation Lab

Faculty Name:	Jeanette (Anderson) Zelhart
Indiana License Number:	28189148A
Full or Part Time:	Full Time
Date of Appointment:	January 8, 2011
Highest Degree:	RN-MSN Transition Completed , Associates in Science – Nursing,
Responsibilities:	Maternity Nursing Theory and Clinical

Faculty Name:	Lori McCourt-O'Donnell
Indiana License Number:	28145439A
Full or Part Time:	Adjunct
Date of Appointment:	August 17, 2011
Highest Degree:	Masters in Science – Nursing
Responsibilities:	Medical Surgical III Nursing Clinicals

Faculty Name:	Belinda Lafferty
Indiana License Number:	28162812A
Full or Part Time:	Adjunct
Date of Appointment:	January 17, 2012
Highest Degree:	Bachelor of Science – Nursing,/ RNC Maternal Newborn Nursing
Responsibilities:	Maternity Clinical

Faculty Name:	Susan Marcek
Indiana License Number:	28195894A
Full or Part Time:	Adjunct
Date of Appointment:	January 17, 2012
Highest Degree:	Bachelor Science – Nursing, Masters Healthcare Administration
Responsibilities:	Maternity Clinical

Faculty Name:	Debra Winston
Indiana License Number:	28078330A
Full or Part Time:	Adjunct
Date of Appointment:	January 17, 2012
Highest Degree:	RN-MSN Transition Completed , Associates in Science – Nursing, Master in Science - Management
Responsibilities:	Medical –Surgical II Nursing Clinical

Faculty Name:	Kimberly Ziegler
Indiana License Number:	28078330A
Full or Part Time:	Adjunct
Date of Appointment:	January 17, 2012
Highest Degree:	Bachelor Science – Nursing Clinical Practitioner
Responsibilities:	Medical – Surgical III Nursing Clinical

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

1. Number of full time faculty: 5 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: HALF TIME - 1

5. Number of adjunct faculty: 12

C. Faculty education, by highest degree only:

1. Number with an earned doctoral degree: 0

2. Number with master's degree in nursing: 9

3. Number with baccalaureate degree in nursing: 7

4. Other credential(s). Please specify type and number: RN-MSN with BSN Coursework completed 2

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;
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.

Signature of Dean/Director of Nursing Program

Margaret Stoffregen-DeYoung 9/19/12

Margaret Stoffregen-DeYoung

Date: September 19, 2012

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.