



ANNUAL REPORT

July 1, 2016 – June 30, 2017

Vocational Nursing Program Psychiatric Technician Program

**DUE DATE:
 SEPTEMBER 30, 2017**

PLEASE PROVIDE ALL REQUESTED INFORMATION.

PROGRAM APPROVAL

SCHOOL/CAMPUS NAME: _____ Full-Time Part-Time

Check Appropriate Box(es): Community College Adult School R.O.P. Private Other

Official Mailing Address: _____

Program Director: _____ Assistant Director (If Any): _____

Director's Office Telephone: (____) _____ Fax: (____) _____ Email Address: _____

BVNPT Approval Dates: Initial Approval: _____ Last Approval: _____ Expiration: _____ Full-Time Part-Time

Bureau of Private Postsecondary Education Approval: Yes: Expiration Date: _____ No Exempt

Other Accreditations: Yes (Please specify): _____ Expiration Date(s): _____ No

CLASS DATA

1. **Board - approved # of students/class:** Full-Time: _____ Date: _____ Part-Time: _____ Date: _____

2. **Approved frequency of admissions:** Full-Time: _____ Date: _____ Part-Time: _____ Date: _____

3. Was an increase in class size or frequency requested during this reporting period? Yes No

If yes, please provide the following information:

◆ Date of Request: _____ # Requested: _____ Date of Approval: _____ # Approved: _____

4. Does the program conduct classes year round? Full-Time: Yes No Part-Time: Yes No

5. For the period **July 1, 2016 through June 30, 2017**, please provide the following information **per class.**

◆ # Applications Received:	<u>Class #1</u>	<u>Class #2</u>	<u>Class #3</u>	<u>TOTAL</u>
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____
◆ # Students Admitted:	<u>Class #1</u>	<u>Class #2</u>	<u>Class #3</u>	<u>TOTAL</u>
List the <u>months</u> and # of students				
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____
◆ # Students Completing Program Requirements:	<u>Class #1</u>	<u>Class #2</u>	<u>Class #3</u>	<u>TOTAL</u>
List the <u>months</u> and # of students				
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____

6. When did you graduate your last class? _____ When is the next class admission? _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE INFORMATION ON A SEPARATE PAGE.

CURRICULUM INFORMATION

Please specify the nursing theory on which your program's **conceptual framework** is based, e.g. Orem, Henderson.

Please specify the format of classes in your curriculum. Block* Integrated* Other (*Please specify*): _____

***For example:**

- **Block Format:** A **Nutrition** course would include **only Nutrition content**.
- **Integrated Format:** A **Cardiovascular Nursing** course would include integrated content **related to clients with Cardiovascular deficits**, including, but not limited to, Anatomy & Physiology, Nutrition, Growth & Development, Critical Thinking, Nursing Process, Patient Education, Nursing Care or Interventions, etc. **Integrated content hours should be designated by parentheses.**

Please provide the number of **Board – approved** hours/units for **every content area** below and the date of Board approval. **Integrated content should be reflected by enclosing the hours in parentheses.** **Total program hours should include the sum of all theory and clinical hours.** Please use an asterisk (*) to indicate prerequisite hours/units.

Date of Approval: _____

Vocational Nursing Programs Only:	Hours/Units	
	Theory	Clinical
A. Anatomy & Physiology		
B. Nutrition		
C. Psychology		
D. Normal Growth & Development		
E. Nursing Fundamentals		
F. Nursing Process		
G. Communication		
H. Patient Education		
I. Pharmacology		
J. Medical-Surgical Nursing		
K. Communicable Diseases		
L. Gerontological Nursing		
M. Rehabilitation Nursing		
N. Maternity Nursing		
O. Pediatric Nursing		
P. Leadership		
Q. Supervision		
R. Ethics & Unethical Conduct		
S. Critical Thinking		
T. Culturally Congruent Care		
U. End-of Life Care		
TOTAL HOURS/UNITS		
TOTAL PROGRAM HOURS/UNITS:		

Date of Approval: _____

Psychiatric Technician Programs Only:	Hours/Units	
	Theory	Clinical
A. Anatomy & Physiology		
B. Nutrition		
C. Psychology		
D. Normal Growth & Development		
E. Nursing Process		
F. Communication		
G. Nursing Science:		
1. Nursing Fundamentals		
2. Med/Surg Nursing		
3. Communicable Diseases		
4. Gerontological Nursing		
H. Patient Education		
I. Pharmacology		
J. Classifications of Developmental Disabilities		
K. Classifications of Mental Disorders		
L. Leadership		
M. Supervision		
N. Ethics & Unethical Conduct		
O. Critical Thinking		
P. Culturally Congruent Care		
Q. End-of Life Care		
TOTAL HOURS/UNITS		
TOTAL PROGRAM HOURS/UNITS:		

ADMISSION, SCREENING & SELECTION PROCESS

1. Please check all **admission criteria** applicable to your program.

- 12th Grade Completion or Equivalent. Is documented proof required prior to admission? Yes No
- Completion of specific admissions test? Yes (*Please specify*): _____ No
- Certification (*check all applicable*): HHA CNA CPR Other (*Please specify*): _____
- Course prerequisites in addition to those listed on Page 2. (*Please specify*): _____
- Are applicants required to demonstrate proficiency in the following? **Select all that apply.**
- Language Proficiency Mathematics Medical Terminology Reading Comprehension
- Other (*Please specify*): _____

2. Please check all **screening and selection criteria** applicable to your program.

- Random Selection Interview Grade Point Average (*Please specify*): _____
- Screening Instrument Used:
- Assessment Technology Institute (ATI) Career Program Assessment Test (CPAT)
- Health Education Systems, Inc. (HESI) Kaplan
- National League for Nursing (NLN) Pre Admission Test of Adult Basic Education (TABE)
- Wonderlic Other (*Please specify*): _____
- Please specify **minimal score required** for admission: _____
- Other (*Please specify*): _____

TIME BASE

Please indicate **type** (FT=Full-Time, PT=Part-Time, D=Day, E=Evening, or WE=Weekend) and **length** of all classes offered.

Type: _____ How is the program divided? Quarters Semesters Modules Other (*Please specify*): _____

Weeks per Quarter/Semester/Module: _____ Total Length of Program: _____ Weeks/Quarters/Semesters

Is a **Preceptorship** included? Yes No Number of Hours: _____ Date of Board Approval: _____

Type: _____ How is the program divided? Quarters Semesters Modules Other (*Please specify*): _____

Weeks per Quarter/Semester/Module: _____ Total Length of Program: _____ Weeks/Quarters/Semesters

Is a **Preceptorship** included? Yes No Number of Hours: _____ Date of Board Approval: _____

Type: _____ How is the program divided? Quarters Semesters Modules Other (*Please specify*): _____

Weeks per Quarter/Semester/Module: _____ Total Length of Program: _____ Weeks/Quarters/Semesters

Is a **Preceptorship** included? Yes No Number of Hours: _____ Date of Board Approval: _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE INFORMATION ON A SEPARATE PAGE.

INSTRUCTIONAL METHODS

1. Does your program utilize **Distance Education/Learning** as an instructional method? Yes No
2. Does your program use self – guided learning modules? Yes No

If yes, **please specify:** _____

3. Does your curriculum include courses that are taught **online or via distance learning**? Yes No

If yes:

- a. In which term/level are online or distance learning courses presented?

Term I Term II Term III Term IV Other (*Please specify*): _____

- b. Which classes are presented **online**?

- 1) Anatomy & Physiology Yes No # Theory Hrs: _____ # Clinical Hrs: _____
- 2) Nutrition Yes No # Theory Hrs: _____ # Clinical Hrs: _____
- 3) Psychology Yes No # Theory Hrs: _____ # Clinical Hrs: _____
- 4) Normal Growth & Development Yes No # Theory Hrs: _____ # Clinical Hrs: _____
- 5) Other: (*Please Specify*) _____ Yes No # Theory Hrs: _____ # Clinical Hrs: _____

4. Does your curriculum include **self – guided learning modules**? Yes No

5. Do your courses include **clinical simulation**? Yes No

If yes:

- a. Is utilization specific to unit content (*for example: Patient Safety*)? Yes No

- b. Which courses include **clinical simulation**?

- 1) **Fundamentals of Nursing** Yes No If yes, please indicate the # of hours & content area.

Theory Hrs: _____ # Clinical Hrs: _____ # Simulation Hrs: _____ Content Area: _____

- 2) **Medical/Surgical** Yes No If yes, please indicate the # of hours & content area.

Theory Hrs: _____ # Clinical Hrs: _____ # Simulation Hrs: _____ Content Area: _____

- 3) **Obstetrical Nursing** Yes No If yes, please indicate the # of hours & content area.

Theory Hrs: _____ # Clinical Hrs: _____ # Simulation Hrs: _____ Content Area: _____

- 4) **Pediatric Nursing** Yes No If yes, please indicate the # of hours & content area.

Theory Hrs: _____ # Clinical Hrs: _____ # Simulation Hrs: _____ Content Area: _____

(Psychiatric Technician Programs Only)

- 1) **Mental Disorders** Yes No If yes, please indicate the # of hours & content area.

Theory Hrs: _____ # Clinical Hrs: _____ # Simulation Hrs: _____ Content Area: _____

- 2) **Developmental Disabilities** Yes No If yes, please indicate the # of hours & content area.

Theory Hrs: _____ # Clinical Hrs: _____ # Simulation Hrs: _____ Content Area: _____

- c. Do instructors hold current certification in clinical simulation? Yes No

- d. Is specialized equipment used? Yes No

Please Specify: _____

EVALUATION OF INSTRUCTIONAL EFFECTIVENESS

1. What criteria do you use to evaluate the effectiveness of your instructional program?

Please specify: _____

2. How frequently do you evaluate your **curriculum**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*):_____

3. How frequently do you evaluate your **instructional methodologies**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*):_____

4. How frequently do you evaluate your **clinical facilities and rotations**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*):_____

5. How frequently do you evaluate the **correlation of clinical rotations to presented theory content**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*):_____

6. How frequently do you evaluate the **effectiveness of faculty** in teaching assigned curricular content?

Monthly Quarterly Annually Biannually Other (*Please Specify*):_____

7. How frequently do you evaluate the **performance of program graduates on licensure examinations**?

Monthly Quarterly Annually Biannually Other (*Please Specify*):_____

7. How frequently do you **revise your curriculum**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*):_____

ASSESSMENT TESTS

1. Does the program require students' completion of assessment tests?

Yes No

◆ If yes, please indicate the **assessment** instrument utilized. (*Check all that apply*)

Assessment Technology Institute (ATI) **BEFORE** Admission Specialty/Level **AFTER** Course Completion

Health Education Systems, Inc., (HESI) **BEFORE** Admission Specialty/Level **AFTER** Course Completion

National League for Nursing (NLN) **BEFORE** Admission Specialty/Level **AFTER** Course Completion

Other (*Please Specify*):_____ **BEFORE** Admission Specialty/Level **AFTER** Course Completion

◆ How many times are students allowed to test? Once Twice Unlimited Other: _____

PLEASE ATTACH A COPY OF THE INSTRUMENT USED, UNLESS RESTRICTED BY COPYRIGHT.

2. **Prior to program completion**, are students required to complete: (*Check all that apply*)

Comprehensive Examination Predictor Examination Other *Please Specify*: _____

◆ Is the exam utilized to:

▪ Evaluate students' **level of achievement** **after** completing your curriculum? Yes No

▪ Evaluate students' **readiness** to complete the **licensure examination**? Yes No

◆ When is the exam administered? Specialty/Level Completion of Term **AFTER** Course Completion

◆ Is a minimum passing score required for program completion? Yes No

If yes, what is the required passing score? _____

◆ Are students **notified** of the requirement **prior** to admission? Yes No

PLEASE ATTACH A COPY OF STUDENTS' NOTIFICATION.

3. Do you utilize students' assessment scores to determine curricular modifications?

Yes No

EXAMINATION REVIEW COURSES

1. Does the program offer review courses? Yes No
If yes, check all that apply: NCLEX/PN® CAPTLE Other (*Please specify*): _____
2. What is the **length** of the review course? 3 Days – 1 Wk. 2 Wks. – 3 Wks. Other (*Please specify*): _____
3. Are students required to pass the review course in order to complete the program? Yes No
4. Are students notified of the requirement **prior** to admission? Yes No
5. Is **enrollment restricted** to your program's enrolled students or graduates? Yes No

CAREER MOBILITY

Relative to career mobility, please check **all types** of nursing and related programs offered by your institution.

- CNA to LVN LVN to PT PT to LVN LVN to ADN Other (*Please specify*): _____

FACULTY MEETINGS

Please indicate the following information regarding your program's **faculty meetings**.

1. **MEETING FREQUENCY:** Weekly Monthly Quarterly Other (*Please specify*): _____
2. **MEETING CONTENT:** (*Please specify frequency per content area*):
- ◆ **Attendance:** Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Curriculum Effectiveness:** Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Curriculum Evaluation/Revision:**
 - Theory-to-Clinical Correlation: Weekly Monthly Quarterly Other (*Please specify*): _____
 - Instructional Methods & Materials: Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Instructor Performance:**
 - Faculty – Faculty Communication: Weekly Monthly Quarterly Other (*Please specify*): _____
 - Student Concerns: Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Student Achievement:**
 - Grading: Weekly Monthly Quarterly Other (*Please specify*): _____
 - Readiness for Progression: Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Effectiveness of Remediation:**
 - Remediation Plans: Weekly Monthly Quarterly Other (*Please specify*): _____
 - Status of Followup Evaluations: Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Criteria for Academic Probation:**
 - # of Students on Probation: Weekly Monthly Quarterly Other (*Please specify*): _____
 - Areas of Student Deficit: Weekly Monthly Quarterly Other (*Please specify*): _____
 - Student Progress: Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Program Evaluation:** Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Clinical Facility Evaluation:** Weekly Monthly Quarterly Other (*Please specify*): _____
 - ◆ **Other (*Please specify*):** _____

CULTURAL DIVERSITY OF STUDENT POPULATION (OPTIONAL)

Given the crisis in health care and nursing shortage, the Board is frequently asked by the Legislature and the Governor's office to provide data regarding the cultural diversity of California's workforce. For that reason, the following data is requested. **Please note, that only aggregate data will be reported, individual programs will not be identified.**

Please complete the table below by listing the number of students in each category for all enrolled classes starting or graduating during the reporting period **July 1, 2016 through June 30, 2017**.

Class Start Date	Projected Graduation Date	African-American	African	Asian/ Pacific Islander	Caucasian	Hispanic	Native American	Other

Submit additional pages if necessary.

<p><i>I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that the information contained in this Annual Report is true and correct.</i></p> <p>Program Director's Name: <i>(Print)</i>: _____</p> <p>Program Director's Signature: _____ Date: _____</p>
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RETURN COMPLETED FORM TO YOUR ASSIGNED NEC
NO LATER THAN SEPTEMBER 30, 2017

Attachment A: Faculty Information

Attachment A should reflect all Board-approved faculty for your program. Please mark through the names of faculty who no longer teach for your program or who vacated the position within the period of this report. The legend for Attachment B is as follows:

- ** Degree:** **A** = Associate Degree; **B** = Bachelors Degree; **M** = Masters Degree;
 D = Doctoral Degree
- *** Position Codes:** **D** = Director; **AD** = Asst. Director; **I** = Instructor or Substitute (nursing);
 AF = Additional Faculty; **TA** = Teacher Assistant
- **** Work Schedule:** **FT** = Full-Time **PT** = Part-Time **S** = Substitute

Attachment B: Clinical Facility Information

Attachment B should reflect all Board-approved clinical facilities in which you have indicated that your program's students received clinical experience during the last **24 months**. Facilities not utilized within that period will be deleted from your program's list of approved clinical facilities. Future use will necessitate the completion of a new Clinical Facility Approval Application. Please mark through any names of facilities you stopped using during this reporting period. The legend for Attachment C is as follows:

- * Non-Use:** Please place a check in this column if the designated facility was not utilized for clinical experience during the last 24 months.
- ** Facility Codes:** **AC** = Acute Care; **AS** = Ambulatory Surgery; **COM** = Community Care;
COR = Corrections; **DC** = Day Care; **GH** = Group Homes;
HH = Home Health; **IC** = Intermediate Care; **SC** = Sub Acute Care;
LTC = Long Term Care; **OP** = Outpatient; **PO** = Physician's Office;
P = Preschool; **PH** = Public Health; **R** = Rehabilitation; **SNF** = Skilled Nursing Facility; **STP** = Specialty Treatment Programs;
SS = Special Schools; **TC** = Transitional Care; **O** = Other (*Please specify*).
- PT Programs Only** - **CDU** = Chemical Dependency Unit;
MHC = Mental Health Clinics; **P HOSP** = Psychiatric Hospitals;
VE = Vocational Education & Training Centers

- *** Clinical Use Codes:** **Fun** = Fundamentals/Nursing Science; **M/S** = Medical/Surgical;
C Dis = Communicable Diseases; **GERON** = Gerontological Nursing; **REHAB** = Rehabilitation Nursing; **MATERN** = Maternity Nursing; **PED** = Pediatric Nursing; **L/S** = Leadership & Supervision.

PT Programs Only - **MD** = Mental Disorders; **DD** = Developmental Disabilities