STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS
2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833-2945
Phone (916) 263-7800 Fax (916) 263-7855 Web www.bvnpt.ca.gov

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.**

	Class #1	Class #2	Class #3	TOTAL
♦ # **Applications Received**:				
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____
♦ # **Students Admitted**:	**Class #1**	**Class #2**	**Class #3**	**TOTAL**
List the **months** and # of students				
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____
♦ # **Students Completing Program Requirements:**	**Class #1**	**Class #2**	**Class #3**	**TOTAL**
List the **months** 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 <u>Board – approved</u> hours/units for <u>every content area</u> below and the date of Board approval. <u>Integrated content should be reflected by enclosing the hours in parentheses</u>. <u>Total program hours should include the sum of all theory and clinical hours</u>. 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.

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.

Program Director's Name: *(Print):* _____

Program Director's Signature: _____ **Date:** _____

RETURN COMPLETED FORM TO YOUR ASSIGNED NEC NO LATER THAN SEPTEMBER 30, 2017

Attachment A: Faculty Information

Complete Attachment A & B on the Web Link Below This Document

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