Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 15 March 2022 – Wednesday 23 March 2022

Virtual Hearing

Name of registrant:	Joanne Louise Gaskarth-Parkhouse
NMC PIN:	96J0530E
Part(s) of the register:	Registered Nurse – Children Nursing Level 1 September 1999
Area of registered address:	Lancashire
Type of case:	Misconduct
Panel members:	David Crompton (Chair, Lay member) Jim Blair (Registrant member) Elaine Biscoe (Registrant member)
Legal Assessor:	Patricia Crossin
Hearings Coordinator:	Margia Patwary
Nursing and Midwifery Council:	Represented by Sapandeep Maini-Thompson, Case Presenter
Mrs Gaskarth-Parkhouse:	Not present and unrepresented
Facts proved:	**Charges 1a, 1b, 1c, 2a, 3, 4, 6, 7, 8, 9**
Facts not proved:	**1d, 1e, 1f and 2b. Charge 5 withdrawn**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Gaskarth-Parkhouse was not in attendance and that the Notice of Hearing letter had been sent to Mrs Gaskarth-Parkhouse's registered email address on 25 January 2022.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Gaskarth-Parkhouse's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Maini-Thompson, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Gaskarth-Parkhouse has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in absence

The panel next considered whether it should proceed in the absence of Mrs Gaskarth-Parkhouse. It had regard to Rule 21 and heard the submissions of Mr Maini-Thompson who invited the panel to continue in the absence of Mrs Gaskarth-Parkhouse. He submitted that Mrs Gaskarth-Parkhouse had voluntarily absented herself.

Mr Maini-Thompson told the panel that the last known communication from Mrs Gaskarth-Parkhouse was an email received on 21 July 2021 and since then there has been no engagement from her.

Mr Maini-Thompson submitted that there had been a lack of engagement from Mrs Gaskarth-Parkhouse with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5

The panel has decided to proceed in the absence of Mrs Gaskarth-Parkhouse. In reaching this decision, the panel has considered the submissions of Mr Maini-Thompson, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Gaskarth-Parkhouse;

- Mrs Gaskarth-Parkhouse has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Mrs Gaskarth-Parkhouse has not provided the NMC with details of how she may be contacted other than her registered email address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses were available to give live evidence and not proceeding may inconvenience the witnesses, their employer and, for those involved in clinical practice, and the clients who need their professional services;
- The charges relate to events that occurred on the night 24 June and morning of 25 June 2019 and further delay may have an adverse effect on the ability of witnesses to recall accurately events;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Gaskarth-Parkhouse in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Gaskarth-Parkhouse's decision to absent herself from the hearing, waive her rights to attend, or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Gaskarth-Parkhouse. The panel will draw no adverse inference from Mrs Gaskarth-Parkhouse's absence in its findings of fact.

Details of charges (as amended)

That you, a registered nurse working on Ward B18 of the Royal Blackburn Hospital on the nightshift of 24-25 June 2019:

1) Whilst responsible for the care of Patient D:

    a) Did not administer IV Flucloxacillin at 12:00am;

    b) Signed that you had administered the medication when you had not;

    c) Did not indicate on the record that the signature had been added to the MAR chart retrospectively;

In the alternative:

    d) Did not ensure you had a second checker when administering IV Flucloxacillin at 12am;

    e) Did not attach a label to the saline bag indicating what medication had been added.

    f) Retrospectively signed that you had administered the medication without indicating on the record that the signature had been added to the MAR chart retrospectively;

2) Your actions in the following charges set out above were dishonest in that:
    a. 1(b) and (c) – sought to give impression you administered medication when you had not;
    b. 1(f) – sought to conceal the fact you had not signed for the medication at the time you administered it.

3) Did not sign that you had administered Patient D's Flucloxacillin at 4:00AM.

4) Signed patient C's MAR chart to indicate you had administered Atorvastatin when you had not.

5) Your actions in charge 4 above were dishonest in that you intended to create a false impression that you had administered medication when you had not.

6) Recorded the following blood glucose reading for Patient A, when you had not taken any blood glucose readings:

    a. 8.2mmol (bedtime 24/6/2019).
    b. 8.2mmol (breakfast 25/6/2019).

7) Recorded a blood glucose reading for Patient B of 10.2mmol (bedtime 24/6/2019), when you had not taken any blood glucose reading.

8) Recorded a blood glucose reading for Patient C of 5.5mmol (breakfast 25/6/2019), when you had not taken any blood glucose reading.

9) Your actions in charges 6-8 were dishonest as you intended to give the impression you had taken blood glucose measurements when you had not.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Maini-Thompson, on behalf of the NMC, to amend the wording of charges 1(d) and 3.

The first suggested amendment was to reflect that Mrs Gaskarth-Parkhouse did not ensure she had a second checker when administering IV Flucloxacillin at 12pm. Mr Maini-Thompson suggested that the entry should instead read '12am *instead of 12.00am'* in order to correct this.

The second amendment related to charge 3. Mr Maini-Thompson noted that this was a minor grammatical amendment and proposed that the word *'no'* should be changed to *'not'.*

> 1)d) Did not ensure you had a second checker when administering IV Flucloxacillin at ~~12pm~~ **12am;**
>
> 3) Did ~~no~~ **not** sign that you had administered Patient D's Flucloxacillin at 4:00AM.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was satisfied that the amendments were minor and did not change the nature of the misconduct alleged and would therefore not prejudice Mrs Gaskarth-Parkhouse. The panel therefore accepted the proposed amendments and altered the wording of the charges to provide more clarity.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Maini-Thompson, on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Gaskarth-Parkhouse.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Matron for the Cardiology Department for Ward B18
- Witness 2: Worked for the Cardiology Department for Ward B18 as a Registered Nurse
- Witness 3 Worked for the Cardiology Department for Ward B18 as Ward Manager
- Witness 4 Worked for the Cardiology Department for Ward B18 as a Registered Nurse

Background

The charges arose whilst Mrs Gaskarth-Parkhouse was employed as a registered nurse by HCR Agency. Mrs Gaskarth-Parkhouse started working for HCR Agency (the Agency) in March 2018. On the night shift of 24 and 25 June 2019 it was Mrs Gaskarth-Parkhouse first shift on the Ward, although she had undertaken shifts on other wards at the Hospital since 2018.

The alleged facts and an overview of the evidence, are as follows:

Mrs Gaskarth-Parkhouse was on duty with two permanent members of nursing staff, Witness 2 and Witness 4. At the end of the shift, Witness 2 and Witness 4 reported to Witness 3 that they had concerns about the treatment Mrs Gaskarth-Parkhouse provided to Patients A, B, C and D overnight. Witness 3 reported these concerns to Witness 1 who investigated the alleged concerns.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

The panel then considered each of the disputed charges and made the following findings.

Charge 1)a)

"That you, a registered nurse working on Ward B18 of the Royal Blackburn Hospital on the nightshift of 24-25 June 2019:

1) Whilst responsible for the care of Patient D:

a) Did not administer IV Flucloxacillin at 12:00am"

This charge is found proved.

In reaching this decision, the panel took into account the evidence and oral evidence of Witness 2 and Witness 4. In addition the panel took into account Patient D's Prescription chart for the time in question.

The panel considered that Mrs Gaskarth-Parkhouse had not administered the midnight dose of Flucloxacillin. Witness 2 was initially alerted to the possible omission of the dose because she had not heard the alarm on the infusion pump. The panel heard from Witness 2 on how the pump system for administration of IV medications works. The alarm on the pump beeps when there are 5 minutes remaining and again when the infusion has completely finished. Witness 2 explained it has to be manually switched off by a nurse. Witness 2 further went onto explain that the alarm regularly woke Patient D on previous occasions. Witness 2 also looked at Patient D's medication chart which was located at the end of the bed and had noted the midnight dose had not been signed for.

The panel considered the witness evidence from Witness 4 who also stated she had not heard Patient D's pump sounding to indicate the completion of the midnight Flucloxacillin infusion which should have been given by Mrs Gaskarth-Parkhouse. Witness 4 stated she was sitting in the nursing station and that she was close enough to Patient D's bed to hear the alarm indicating the end of the infusion.

The panel also explored the likelihood of the midnight dose being given by a different method that would not have required use of the infusion pump. However the panel heard evidence that usual practice in the hospital at the time was to use the pump for administering IV medications. Mrs Gaskarth-Parkhouse did not report that she used an alternative method either when first asked by Witness 2 or in her email of 8 July 2019. Furthermore, it would appear, from Patient D's records, that the infusion pump had been used at 20.30 by Mrs Gaskarth-Parkhouse and the panel considered it highly unlikey a different method of infusion would have been used for the midnight dose.

The panel therefore concluded that, Mrs Gaskarth-Parkhouse did not administer IV Flucloxacillin at 12:00am to Patient D.

Accordingly, **Charge 1)a)** is found proved.

Charge 1)b

1) Whilst responsible for the care of Patient D:

b) Signed that you had administered the medication when you had not;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and oral evidence of Witness 2.

The panel found that Mrs Gaskarth-Parkhouse did not administer Flucloxacillin, although Mrs Gaskarth-Parkhouse stated she had. It therefore logically followed that Mrs Gaskarth-Parkhouse had signed the MAR chart to indicate she had adminstered Flucloxacillin when she had not done so.

The panel heard evidence from Witness 2 who stated as follows:

"…I took the prescription chart and went into the staff room to find the Registrant and ask her about if she had given the medication. The registrant was sat at the table in the staff room. I showed her the prescription chart then asked her about whether she had given the Flucloxacillin by saying "I am not checking up on you but it's just because I've looked after Patient D before, have you given the 12 o'clock antibiotic?" I cannot remember her precise words but recall that she specifically said she had administered Patient D's Flucloxacillin but had forgotten to sign Patient D's prescription chart for it. The Registrant was adamant that she had given the medication and said this to me clearly.

I wasn't sure about this so I then challenged the registrant and said "alright ok, who have you got it checked by?" by which I meant, which nurse had she asked to be the second checker when she drew up the medication. I told her that Ms Horlador had said that she had not been asked by the Registrant to be the checker and that I had not done it either. The Registrant said "I've just done it". I took this to indicate that she had not got a second checker. I replied "you know you're meant to get it checked don't you?" and she said "oh yeah but I just put it up because it was running late" which I interpreted to mean she had administered it without a second checker because she was running later then the schedule. I took this response to indicate that she knew I was right, and that she had acted incorrectly. She then signed the prescription chart in front of me…"

Having heard the evidence of Witness 2 the panel concluded that Mrs Gaskarth-Parkhouse had signed to indicate she had adminsitered Flucloxacillin when she had not done so.

Accordingly, **Charge 1)b)** is found proved.

Charge 1)c

1) Whilst responsible for the care of Patient D:

c) Did not indicate on the record that the signature had been added to the MAR chart retrospectively;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, oral evidence of Witness 2 and the medical records for Patient D.

The panel found that Mrs Gaskarth-Parkhouse did not indicate in Patient D's record that the signature on the MAR chart, referred to Witness 2's evidence, had been added retrospectively.

The panel accepted the evidence of Witness 2 who stated that when signing retrospectively, this should be noted on the patient's notes or MAR charts.

Accordingly, **Charge 1)c)** is found proved.

Charges 1)d)-f) were not proved having been charged in the alternative to **1)a)-c).**

Charge 2)a

2 a) Your actions in the following charges set out above were dishonest in that:

a. 1(b) and (c) – sought to give impression you administered medication when you had not;

This charge is found proved.

In reaching this decision, the panel took into account the written evidence and oral evidence of Witness 2 and Witness 4.

The panel found that Mrs Gaskarth-Parkhouse had been dishonest as she signed the chart to indicate that she had administered Flucloxacillin to Patient D at midnight when she had not. The panel was of the view that this was a deliberate act designed to give the impression that the medication had been given when it had not. There is no evidence before the panel to indicate Mrs Gaskarth-Parkhouse's actions amounted to a careless mistake. In addition Mrs Gaskarth-Parkhouse's failure to retrospectively mark her signature on the MAR chart was also evidence of a dishonest intent to conceal her omission.

The panel therefore concluded that, Mrs Gaskarth-Parkhouse actions set out in 1)b) and 1)c) were dishonest as they sought to give the impression she had administered medication when she had not.

Accordingly, **Charge 2)a)** is found proved.

Charge 2)b)

Accordingly, the panel found this charge was not found proved as **Charge 1)f)** was not found proved.

Charge 3)

3. Did not sign that you had administered Patient D's Flucloxacillin at 4:00AM.

This charge is found proved.

In reaching this decision, the panel took into account the written evidence in the exhibit bundle and the evidence from Witness 2.

The panel accepted the evidence of Witness 2 that there was no signature recorded by Mrs Gaskarth-Parkhouse on Patient D's MAR chart in relation to the 4:00AM dose of Flucloxacillin. Witness 2 gave evidence that she was confident that Patient D received the medication dose, as she was the second checker, and that Mrs Gaskarth-Parkhouse had not signed for this dose.

Accordingly, the panel found **Charge 3** proved.

Charge 4)

4) Signed patient C's MAR chart to indicate you had administered Atorvastatin when you had not.

This charge is found proved.

In reaching this decision, the panel took into account the written evidence and oral evidence of Witness 3.

The panel noted the email, from Mrs Gaskarth-Parkhouse dated on 8 July 2019, duing the Trust investigation, her comment that "…I did the medication round and instructed and gave out tablets to my allocates patients, one gentlemen had refusing his statin which I didn't give I must of signed my intials instead of the code number…"

The panel further noted evidence from Witness 3 who stated in her oral evidence that Patient C had refused the Atorvastatin due to side effects and was waiting for this medication to be reviewed by the consultant. Witness 3 had no reason to believe Patient C was confused.

When considering all the evidence the panel concluded Mrs Gaskarth-Parkhouse had adminstered medication when she had not.

Accordingly, the panel found **Charge 4** proved.

Charge 5)

No evidence was presented by the NMC and this charge was not found proved.

Charge 6)

6) Recorded the following blood glucose reading for Patient A, when you had not taken any blood glucose readings:

    a. 8.2mmol (bedtime 24/6/2019),
    b. 8.2mmol (breakfast 25/6/2019)

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and oral evidence of Witness 1, 2 and 3. In particular the panel took into account the recorded blood sugar readings in relation to Patient A.

The panel heard evidence from Witness 2 that Mrs Gaskarth-Parkhouse borrowed Witness 2's barcode so she could use the glucometer. In her evidence Witness 2 stated:

"…The registrant approached me towards the end of the night shift on 25 June 2019 to ask for my barcode, which would be needed to use the glucometer. I gave her my badge with my barcode on it…"

Mrs Gaskarth-Parkhouse also confirmed this in her second response to the hospital in her email dated on 8 July 2021 where she stated:

"…I did check blood sugar and did these by using a staff members ID badge the one in the morning I did after calibrating the machines which I did take a while…"

The panel heard evidence that the barcode was required in order to use the glucometer but no readings were recorded for Patients A, B and C on any of the machines during that shift. In her evidence Witness 1 stated:

"…The Registrant recorded the following blood glucose readings on paper for Patients A, B and C. Patient A (Exhibit KC12): 8.2mmol (bedtime 24/6/2019), 8.2mmol (breakfast 25/6/2019)…"

Witness 1 also added in her evidence:

"…As the electronic recordings did not show any evidence of any blood glucose readings having been taken on the shift for these particular patients, I asked for the full report of all of the blood glucose readings taken for the shift in case there had been a technical error. I was sent a spreadsheet from the Point of Care team…"

In relation to the response made by Mrs Gaskarth-Parkhouse in her email dated 8 July 2019 Witness 1 gave evidence as follows:

"…She said that she had recalibrated the machine which took a while but was successful. However, if the machine had been recalibrated this would have shown up on the records and this was not present in the report I attach as **Exhibit KC22** above…"

The panel further noted the oral evidence of Witness 3 who stated that:

"…It was clear that the registrant had not taken the three patients' blood glucose using the machine, as no records of these readings were found in the readings and therefore, the recordings in their charts were not accurate. The only way to check blood glucose is by using the glucose machine, so it appeared to me that the recordings were written manually by the registrant in the patient charts were made up and not from readings taken by the machine. Recordings from the machine are also written manually as when the you [sic] check blood glucose the result is instant, so that then is noted on the blood glucose chart, and only when the machine is docked back in the docking station does the result go onto the electronic system…"

The panel took account of the evidence from the witnesses that Patient A, B and C did not have their own personal glucometers and therefore were unable to provide any personal readings.

After taking this evidence into account the panel concluded that it was more likely than not that the registrant had recorded blood glucose readings for Patient A when she had not taken any blood glucose readings.

Charge 7)

7) Recorded a blood glucose reading for Patient B of 10.2mmol (bedtime 24/6/2019), when you had not taken any blood glucose reading.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and oral evidence of Witness 1, 2 and 3. In particular the panel took into account the recorded blood sugar readings in relation to Patient B.

In reaching this decision, the panel took account of the same evidence as noted in charge 6. After taking this evidence into account the panel concluded that it was more likely than not that the registrant had recorded a blood glucose reading for Patient B when she had not taken a blood glucose reading.

Charge 8)

8) Recorded a blood glucose reading for Patient C of 5.5mmol (breakfast 25/6/2019), when you had not taken any blood glucose reading.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and oral evidence of Witness 1, 2 and 3. In particular the panel took into account the recorded blood sugar readings in relation to Patient C.

In reaching this decision, the panel took account of the same evidence as noted in charge 6. After taking this evidence into account the panel concluded that it was more likely than not that the registrant had recorded a blood glucose reading for Patient C when she had not taken a blood glucose reading.

Charge 9)

9) Your actions in charges 6-8 were dishonest as you intended to give the impression you had taken blood glucose measurements when you had not.

This charge is found proved.

In considering this charge the panel took account of its findings that the blood sugar readings have been falsified on four occasions involving three patients in Mrs Gaskarth-Parkhouse's care. The panel had no evidence before it to show that Mrs Gaskarth-Parkhouse's actions were the result of careless mistakes or made in error. The panel found these actions to be dishonest as they were a deliberate attempt to create the impression that she had taken blood sugar readings when she had not done so.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Gaskarth-Parkhouse's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mrs Gaskarth-Parkhouse's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*

Mr Maini-Thompson invited the panel to take the view that the facts found proved amounted to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and submitted the NMC say Mrs Gaskarth-Parkhouse's actions amounted to breaches of the Code and fell short of the standards expected of a registered nurse.

Mr Maini-Thompson submitted as follows:

1. The NMC submits that by reason of her misconduct, the Registrant's fitness to practice is impaired. The Registrant's conduct was dishonest and placed vulnerable patients at risk of harm. It would place others at risk of harm if repeated.

2. The NMC submits that, as a registered nurse, the Registrant is currently a risk to the health, safety or wellbeing of the public. It is submitted that by reason of her misconduct, her continued practice would diminish public confidence and professional standards.

3. The NMC submits the Registrant has broken Rule 20 of the Code of Conduct in respect of Patients A, B, C and D – on account of the fact that the Registrant sought to give the impression that she had discharged her professional duties when in fact

she had not.

Rule 20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.

4. With the panel having found charges 1a, 1b, 1c, 2a, 6, 7, 8 and 9 proven, it is submitted the Registrant failed to act with integrity and honesty at all times.

5. It is submitted that the Registrant has broken Rule 10 of the Code of Conduct in respect of Patients A, B, C and D – on account of the fact that the Registrant did not take accurate and contemporaneous records.

Rule 10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

6. With the panel having found Charges 1b, 1c, 3, 4, 6, 7, 8 and 9 proven, it is submitted the Registrant failed to keep clear and accurate records at all times and she failed to complete records without any falsification.

7. It is submitted that there are three aggravating factors in this case:

    a. First, the Registrant engaged in multiple acts of dishonest record keeping in a single shift to cover up clinical failings and/or omissions in respect of several patients.

    b. Second, the Registrant has shown no insight into significant areas of concern in the case. This is demonstrated by the vague nature of her reflections during the local investigation.

    c. Third, the Registrant did not provide a reflective statement or response to the NMC.

8. There is further no evidence of any remediation on the part of the Registrant.

9. The Registrant admitted to her error in documenting that Patient C received his statin (Charge 4).

10. The NMC notes that the employment status of the Registrant is currently unknown.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code and NMC guidance on the professional duty of candour.

The panel was of the view that Mrs Gaskarth-Parkhouse's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Gaskarth-Parkhouse's actions amounted to breaches of the Code. Specifically:

10 Keep clear and accurate records relevant to your practice

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct or impairment.

In relation to charge 1a, the panel found that the failure to administer the midnight dose of Flucloxacillin could be considered a genuine oversight. In her evidence Witness 2 stated "…No harm would have been caused as long as she had admitted it…" Although it was a clinical error and poor practice, the panel concluded that, in itself, it did not amount to misconduct.

In relation to charge 1b, the panel considered that Mrs Gaskarth-Parkhouse's actions were dishonest in that she knew that she had not administered the medication to Patient D at the times stated. The panel considered that signing medication notes to show a prescribed medication had been administered when it had not, could have had serious consequences for the patient and consequently put the patient at risk of serious harm. The panel found that Mrs Gaskarth-Parkhouse's actions at charge 1b fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

In relation to charge 1c, the panel considered that Mrs Gaskarth-Parkhouse's actions were dishonest as she did not indicate either on the MAR chart or elsewhere in Patient D's record, that her signature for the midnight Flucloxacillin dose had been added retrospectively. The panel found that Mrs Gaskarth-Parkhouse's actions at charge 1c fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

In relation to charge 2a, the panel considered that Mrs Gaskarth-Parkhouse's actions were dishonest in that she knew that she had not administered the medication when she signed she had done so. Furthermore, the panel took the view that failing to record in the patient notes that her signature was retrospective was an attempt to hide the original falsehood. The panel therefore, found that Mrs Gaskarth-Parkhouse's actions at charge 2a were dishonest and fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

In relation to charge 3, the panel considered that Mrs Gaskarth-Parkhouse's failure to sign for the 04:00 dose of Flucloxacillin was poor practice but amounted to a recording error

rather than misconduct. The panel found that Mrs Gaskarth-Parkhouse's actions at charge 3 did not fall sufficiently short of the conduct and standards expected of a nurse to amount to serious misconduct.

In relation to charge 4, the panel noted that in her email of 8 July 2019 Mrs Gaskarth-Parkhouse conceded that she had made a genuine error when signing Patient D's MAR chart. The panel concluded that Mrs Gaskarth-Parkhouse's actions were a recording error and therefore did not meet the misconduct threshold.

In relation to charge 6, the panel considered that Mrs Gaskarth-Parkhouse's actions were dishonest in that she knew she had entered fictitious blood glucose readings in Patient A's records. Patient A had insulin dependent diabetes. Therefore the fictitious blood glucose readings could have led to him receiving an incorrect dose of insulin, with potentially serious consequences. In considering this the panel took into account the evidence from Witness 1 who stated as follows:

"…There could have been very serious consequences in respect of the Registrant's actions. Patient A was prescribed insulin. Therefore, if it was true that the Registrant falsified the glucometer records for this patient then this could be very serious as the patient could potentially receive the wrong care. This was because the nurse of the following shift would provide care to the patients based on these readings which would not be accurate. This could therefore have caused very serious health concerns such as causing the patients to go into a coma if they became either hyper or hypoglycaemic. These are really serious conditions which can potentially be life threatening…"

The panel therefore found that Mrs Gaskarth-Parkhouse's actions at charge 6 fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

In relation to charge 7, the panel considered that Mrs Gaskarth-Parkhouse's actions were dishonest in that she knew she had entered a fictitious blood glucose reading in Patient B's records. The panel found that Mrs Gaskarth-Parkhouse's actions at charge 7, similar

to the findings in charge 6, fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

In relation to charge 8, the panel considered that Mrs Gaskarth-Parkhouse's actions were dishonest in that she knew she had entered fictitious blood glucose readings in Patient C's records. The panel found that Mrs Gaskarth-Parkhouse's actions at charge 8, similar to the findings in charge 6, fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

In relation to charge 9, the panel considered that Mrs Gaskarth-Parkhouse's actions, as found in charges 6, 7 and 8, were fundamentally dishonest. Therefore, the panel found that Mrs Gaskarth-Parkhouse's dishonest actions at charge 9 fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Gaskarth-Parkhouse's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel had regard to this test and found that all four limbs were engaged in this case. The panel was of the view that Mrs Gaskarth-Parkhouse put patients at an unwarranted risk of harm as a result of her actions. In particular, the panel took note of the evidence of Witness 1 who stated:

"…It is serious if the Registrant falsified the records, predominantly because it would put the safety of the patients concerned at risk. This action would also breach the Registrant's duty to be honest regarding errors and also demonstrate a lack of integrity…"

In addition, the panel concluded that Mrs Gaskarth-Parkhouse's failure to carry out adequate patient care when administering medication and carrying out tests, breached one of the fundamental tenets of the profession and therefore brought its reputation into disrepute.

In its consideration of whether Mrs Gaskarth-Parkhouse has remediated her practice, the panel had regard to the case of *Cohen v General Medical Council (*quoted in *Grant),* in which the court set out three matters which it described as being '*highly relevant'* to the determination of the question of current impairment:

'(a) Whether the conduct that led to the charge(s) is easily remediable?

(b) Whether it has been remedied?

(c) Whether it is highly unlikely to be repeated?'

The panel was satisfied that the misconduct in this case is ultimately capable of remediation. In considering whether the misconduct has been remedied, the panel did not a reflective statement by Mrs Gaskarth-Parkhouse's to demonstrate how her actions gave rise to concern, or how she would act differently in the future. The panel noted Mrs Gaskarth-Parkhouse's lack of engagement in this hearing and that it also had no evidence to suggest that Mrs Gaskarth-Parkhouse's had completed any relevant training since these events to address the failings in her practice. The panel took the view that there was no evidence before it to suggest that if faced with similar circumstances in the future, Mrs Gaskarth-Parkhouse's would act differently. The panel had no evidence from Mrs Gaskarth-Parkhouse of any insight, remorse or regret in relation to the events of the night shift on the 24 June 2019. As such, the panel considered that there is a real risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objective of the NMC is to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is also required. It considered that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Gaskarth-Parkhouse's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Gaskarth-Parkhouse's fitness to practise is currently impaired.

Submissions on sanction

Mr Maini-Thompson submitted that the appropriate sanction in Mrs Gaskarth-Parkhouse is that of a strike-off. He noted that the panel has found that the Mrs Gaskarth-Parkhouse engaged in serious misconduct and that her fitness to practice is impaired on the basis of both public protection and the public interest.

He said that a strike-off order is necessary to maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

He submitted that absent fuller admissions and detailed evidence of insight, remorse or regret, this case involves multiple counts of clinical dishonesty, albeit on a single shift, whilst the Mrs Gaskarth-Parkhouse was responsible for the care of extremely vulnerable patients.

He submitted that absent detailed remediation, this case raises serious concerns about the Mrs Gaskarth-Parkhouse's integrity and accordingly the NMC submits there is a real risk of repetition.

Decision and reasons on sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Gaskarth-Parkhouse off the register. The effect of this order is that the NMC register will show that Mrs Gaskarth-Parkhouse has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Having found Mrs Gaskarth-Parkhouse's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate, and although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Repeated dishonesty, along with multiple falsification of records
- Mrs Gaskarth-Parkhouse's has not acknowledged the seriousness of her actions or the potential impact on Patient A, B, C and D
- Lack of insight, empathy or remorse
- Lack of reflective submission

The panel also took into account the following mitigating features:

- Two Testimonials from nursing colleagues
- Early concession regarding charge 4 in the email of 8 July 2019

Further the panel had regard to the NMC sanctions guidance 'Considering sanctions for serious cases'. The panel determined that Mrs Gaskarth-Parkhouse's misconduct was serious in that it involved a breach of the professional duty of candour by deliberate attempts to conceal failures of patient care.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered whether a caution order would be appropriate in the circumstances. The panel took into account the SG, which states that a caution order may be appropriate where:

> *"…the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise Committee wants to mark that the behaviour was unacceptable and must not happen again."*

The panel considered that Mrs Gaskarth-Parkhouse's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the findings of dishonesty and the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Gaskarth-Parkhouse's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Mrs Gaskarth-Parkhouse's registration would not adequately address the seriousness of this case and would not protect the public or satisfy the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour'*

The panel considered that this was not a single instance of misconduct. Further, it considered that Mrs Gaskarth-Parkhouse has not displayed any insight into her misconduct and its impact on patients, and that there remains a risk of the misconduct being repeated.

The panel found that whilst the charges relate to one shift and 4 patients, Mrs Gaskarth-Parkhouse failed to take multiple blood sugar readings and falsified patient records to imply that they had been taken. The panel also noted Mrs Gaskarth-Parkhouse had no insight into the significance of her misconduct. The panel gave consideration to the testimonials provided however it found it could not attach much weight to them. Although they confirmed Mrs Gaskarth-Parkhouse had been working as nurse until July 2021 they did not contain information that related to the misconduct.

The panel has found that, because of Mrs Gaskarth-Parkhouse lack of insight, there is a likelihood of repetition and, as a consequence, Mrs Gaskarth-Parkhouse poses a risk to patients.

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that Mrs Gaskarth-Parkhouse's misconduct raises concerns about her professionalism, and considered that other nurses would find it difficult to place their confidence in a colleague who had acted in such a dishonest manner, and placed patients at risk of harm. Further, members of the public would find it difficult to place their trust in a nurse who had falsified records and put patients at risk of significant harm. The panel noted that the public expect nurses to provide safe care, be honest and act with integrity, and importantly respond with candour when mistakes are made. Mrs Gaskarth-Parkhouse failed in respect of this.

Mrs Gaskarth-Parkhouse's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Gaskarth-Parkhouse's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Gaskarth-Parkhouse's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel also considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Decision and reasons on interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Gaskarth-Parkhouse's own interest until the striking-off sanction takes effect.

The panel took account of the submissions made by Mr Maini-Thompson and it accepted the advice of the legal assessor.

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order, with immediate effect, for a period of 18 months to allow for any potential appeal period.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Mrs Gaskarth-Parkhouse is sent the decision of this hearing in writing.

That concludes this determination.