

**Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Meeting**

30 September 2019

Nursing and Midwifery Council, 114-116 George Street, Edinburgh, EH2 4LH

Name of registrant:	Edith Magaly Parkhouse
NMC PIN:	83Y2323E
Part(s) of the register:	Registered Mental Health Nurse – Sub Part 1 (29 November 1993) Registered Mental Health Nurse – Sub Part 2 (13 February 1985)
Area of Registered Address:	Chile
Type of Case:	Misconduct
Panel Members:	Wendy Yeadon (Chair, Lay member) Claire Matthews (Registrant member) Geoffrey Baines (Lay member)
Legal Assessor:	Marian Gilmore
Consensual Panel Determination:	Accepted
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Service of Notice of Meeting

The panel received information from the legal assessor concerning service of the notice of meeting. Notice of the meeting was sent to Mrs Parkhouse's registered address by first class post and by recorded delivery on 28 August 2019, stating that a meeting would be held no sooner than 30 September 2019 and that she should contact the NMC by 24 September 2019 if she wanted to provide the panel with any written evidence.

The panel has heard and accepted the advice of the legal assessor.

The panel noted that the appropriate notice had been served on 28 August 2019 which was more than 28 days before this meeting. The panel was satisfied that there was good service of the notice dated 28 August 2019 in accordance with Rules 11A and 34 of the Fitness to Practise Rules 2004 (as amended) (the Rules).

Consensual panel determination

The panel was provided with a provisional agreement of a consensual panel determination that had been reached with regard to this case between the NMC and Mrs Parkhouse.

The agreement, which was put before the panel, sets out Mrs Parkhouse's full admission to the facts alleged in the charges, that Mrs Parkhouse's actions amounted to misconduct, and that Mrs Parkhouse's fitness to practise is currently impaired by reason of misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a striking-off order.

The panel has considered the provisional agreement reached by the parties.

That provisional agreement reads as follows:

"The Nursing and Midwifery Council and Edith Magaly Parkhouse ('the Registrant'), PIN 83Y2323E, ('the parties') agree as follows:

The Charges

1. The Registrant admits the following charges:

That you, a registered nurse, while employed as the registered manager of Garston Moor Nursing Home:

1. *Failed to provide and / or ensure adequate patient care and safety for Resident A in that you did not ensure:*
 - a. *Regular two hourly repositioning.*

- b. *The use of a barrier cream.*
 - c. *Adequate steps to prevent the resident's pressure sore from deteriorating.*
 - d. *Regular personal care.*
2. *Failed to provide and / or ensure adequate patient care and safety for Resident B, in that you did not ensure:*
- a. *Adequate care of the resident's fungating breast wound.*
 - b. *Adequate record keeping in relation to the resident's fungating breast wound.*
3. *Failed to provide and / or ensure adequate patient care and safety for Resident C, in that you:*
- a. *Did not ensure the adequate management of, and / or record keeping in relation to, the resident's diabetes.*
 - b. *Did not arrange a review of the resident's insulin with their GP on their discharge from hospital.*
 - c. *On 6 March 2016:*
 - i. *Said words to the effect of "He's just playing silly buggers" in response to staff not being able to rouse the resident.*

ii. Did not take the resident's blood sugar levels and / or clinically assess the resident when staff reported not being able to rouse the resident.

iii. Did not ensure the resident's urethral catheter bag was appropriately attached.

4. Failed to provide and / or ensure adequate patient care and safety for Resident D, in that you:

a. Did not ensure an adequate chair assessment for the resident.

b. Allowed the practice of managing the resident's aspiration risk by use of a fizzy drink.

c. Did not ensure that the resident had a SALT assessment carried out.

d. Did not ensure intervention relating to the resident's type 7 bowel movements.

e. Did not ensure an up to date moving and handling assessment for the resident.

f. Did not ensure that the resident was referred to a speech and language therapist.

5. Failed to provide and / or ensure adequate patient care and safety for Resident E in that you did not ensure:

- a. *A clear pathway regarding risk assessments and / or referrals regarding the resident's falls.*
 - b. *The resident was provided with a bed suitable for their needs.*
- 6. *Failed to provide and / or ensure adequate patient care and safety for Resident F in that you did not ensure a timely SALT assessment for the resident.*
- 7. *Failed to provide and / or ensure adequate patient care and safety for Resident G, in that you did not ensure:*
 - a. *The carrying out, or in the alternative the recording, of a continence assessment.*
 - b. *The resident was repositioned at night.*
- 8. *Failed to provide and / or ensure adequate patient care and safety for Resident H, in that you:*
 - a. *Did not ensure adequate assistance with toileting.*
 - b. *On 21 April 2016, did not ensure that the resident was attended to as regards personal hygiene.*
- 9. *Failed to provide and / or ensure adequate patient care and safety for Resident I, in that you did not ensure:*
 - a. *The administration of the resident's prescribed diprobase emollient.*

b. The carrying out of:

i. a falls risk assessment

ii. a bed rails assessment

iii. a falls risk management plan

iv. an absconding risk assessment

10. Failed to provide and / or ensure adequate patient care and safety for Resident J in that you did not:

a. Ensure that the resident was given personal care by female staff only.

b. Ensure a SALT assessment was carried out.

c. Take adequate steps to ensure that Resident K would not enter Resident J's room.

11. Failed to provide and / or ensure adequate patient care and safety for Resident K in that you did not ensure that the resident was given personal care by female staff only.

12. Failed to provide and / or ensure adequate patient care and safety for Resident L in that you:

a. Did not ensure the resident had 1:1 support as recommended.

- b. Served the resident with four weeks' notice to leave the Home when this was not clinically justified.*
- c. Did not take appropriate action in relation to the resident lying in one or more of the other residents' beds.*

13. Failed to provide and / or ensure adequate patient care and safety for Resident M in that you did not ensure:

- a. The accuracy of the resident's Waterlow score and / or pressure sore grading.*
- b. The assessment for and / or provision of hoists or slings for the resident.*

14. Failed to provide and / or ensure adequate patient care and safety for Resident N, in that you did not ensure:

- a. The correct dressing was used and / or applied correctly for the resident's wound.*
- b. The provision of the correct mattress and / or correct positioning of the mattress.*

15. Failed to provide and / or ensure adequate patient care and safety for Resident O in that you did not ensure that the resident was protected from the risk of skin damage and / or pressure ulcers.

16. Failed to provide and / or ensure adequate patient care and safety for Resident P in that you did not ensure that the resident was protected from the development of pressure ulcers.

17. *Allowed preferential treatment of Resident Q without clinical justification.*
18. *Allowed the provision of unprescribed fluid thickeners to one or more residents.*
19. *Failed to respond appropriately to concerns that staff were falsifying records at the Home.*
20. *Failed to ensure that all residents received adequate amounts of fluids and / or regular meals.*
21. *Failed to ensure the provision of a call bell for all residents.*
22. *Failed to ensure the timely changing of one or more residents' incontinence pads and / or the provision of said pads.*
23. *Failed to design and / or implement adequate audits or quality assurance checks in relation to:*
 - a. *MAR charts.*
 - b. *Residents' daily notes.*
 - c. *Fluid charts.*
 - d. *Care plans.*
 - e. *Risk assessments.*

- f. Medication stick records.*
- g. Nutrition records and / or weight management.*
- h. Turning / repositioning charts.*
- i. Bowel monitoring.*

24. On one or more occasions, allowed the recording of inaccurate information and / or allowed a lack of full information on residents' records in relation to:

- a. Fluid output and / or input.*
- b. Toileting / bowel monitoring.*
- c. Food / meal provision.*
- d. Turning / repositioning.*
- e. Provision of fluid thickeners.*
- f. Supplements.*
- g. Medication administration.*
- h. Washing / hygiene / personal care.*
- i. Activities.*
- j. Falls.*

k. Care plans.

25. Your actions at charge 24 were dishonest in that you sought to create and / or maintain the impression that residents were receiving a higher standard of care than they actually were.

26. Failed to ensure an adequate standard of medication management at the Home in that you did not ensure:

a. The storage of medicine at the appropriate temperature.

b. That all medication was within the relevant expiry date.

c. That all residents received medication as prescribed.

27. Failed to ensure an adequate standard of hygiene and / or infection control at the Home, including in relation to:

a. The cleanliness of rooms and / or common areas and / or equipment and / or furnishings.

b. The adequate provision of creams.

c. The provision of clean clothes for those residents who had soiled themselves.

d. Laundry and / or the handling of soiled linen.

e. Provision of gloves, aprons, plastic bags for soiled incontinence aids and/ or paper hand, and / or the use of these by staff.

f. Food storage.

g. Responding to complaints from staff about the level of cleanliness at the Home.

h. Oral care for the residents.

28. Allowed some residents' doors to be locked at the Home without clinical justification and / or without ensuring the undertaking of relevant assessments for this measure.

29. Failed on one or more occasions to adequately cooperate with the investigations or assessments of Person 1 and / or Person 2 in that you:

a. Did not allow full access to residents' paper care plans.

b. Did not provide copies of policies relating to:

i. Mental capacity.

ii. Best interest decisions.

iii. Identifying bad practices.

iv. Potential abuse.

30. Failed to ensure that relatives of deceased residents were informed of residents' deaths in a timely manner.

31. Failed to ensure the existence of a comprehensive diabetes policy and / or handling policy at the Home.

32. Failed to ensure that safeguarding incidents were appropriately managed in that you did not:

- a. Ensure such incidents were fully and accurately reported on one or more occasions.*
- b. Seek external advice in relation to challenging and aggressive behaviour.*
- c. Suspend a staff member in a timely manner following allegations of abuse against that staff member.*
- d. Applied pressure on Person 3 to not report safeguarding concerns.*

33. Your actions at charge 32 were dishonest in that you sought to create the impression that there had not been an incident or incidents meriting a safeguarding referral.

34. Failed to ensure all staff were adequately inducted and / or trained in and or all the areas as covered in Schedule A.

35. Failed to provide adequate supervision and / or monitoring of staff at the Home.

36. Failed to adapt the Home to the needs of dementia residents, in that you:

- a. *Did not ensure that deprivation of liberty safeguard applications had been made when appropriate.*
- b. *Did not provide the appropriate furnishings and décor for these residents' needs.*
- c. *Did not ensure the physical security of the Home's premises.*

37. Failed to ensure the existence of adequate systems for the assessment and / or monitoring and / or management of residents':

- a. *Bowel movements.*
- b. *Weight loss.*
- c. *Blood sugar levels.*
- d. *Pressure sores.*

38. Failed to ensure, as regards staffing at the Home:

- a. *Safe staffing levels.*
- b. *Appropriate recruitment practices.*

39. On an unknown date, said to Colleague 1 words to the effect of "Are you going to come and wash the bottles every day because I'm not" in response to Colleague 1's request to purchase water bottles for residents.

40. On 8 April 2016, failed to identify a pressure sore for an unidentified resident.

41. Failed to adequately improve standards at the Home between 2012 and 2016.

42. Otherwise failed in your duties as registered manager in that you did not:

a. Ensure that all care plans for the residents were available on the Home's iPods.

b. Ensure best interest decisions were made in relation to residents being placed in shared bedrooms.

c. Ensure end of life care was person-centred in relation to the use of syringe pumps.

d. Provide input to the initial service improvement plan of Person 3.

e. Ensure the appropriate use of pressure cushions for residents.

43. Your actions at charges 19, 23, 24, 25, 32, 33 and / or 35 contributed to a culture of dishonesty at the Home.

And, in light of the above, your fitness to practice is impaired by reason of your misconduct.

The Agreed Facts

2. The Registrant appears on the register of nurses and midwives maintained by the NMC as a Registered Nurse – Mental Health. She registered in March 2000.
3. The NMC received a referral regarding the Registrant on 2 September 2016 from the Team Manager at Newton Abbot Community Health and Social Care; operated by Devon County Council (DCC). At the material time, the Registrant was the Registered Manager at Garston Manor Nursing Home (“the Home”). The Registrant and her husband owned the Home and the Registrant also worked shifts as a registered nurse at the Home.
4. Following several whistle-blowing concerns raised with the Care Quality Commission (CQC) and DCC, the Home received an unannounced inspection from CQC on 22 February 2016. A multi-agency safeguarding meeting was held on 25 February 2016 as the concerns raised were partially substantiated.
5. Those concerns included the following areas:
 - Care plans that were not updated
 - Inappropriate/lack of knowledge in relation to diabetes and diabetes management
 - Residents fluid intake and dehydration
 - Lack of SALT referrals
 - Medication management
 - Deprivation of Liberty (DOLS) concerns with some residents being locked in their rooms who did not have capacity to consent
 - Incontinence care
 - Lack of falls risk assessments
 - Lack of safeguarding and CQC referrals
 - Falsification of clinical records

- Limited activities for residents
 - Residents weight loss
 - Pressure area care
 - Inappropriate management of staff when suspected of abuse
6. The CQC carried out further inspections on 8, 11 and 15 March 2016. On 29 March 2016, DCC and Torbay and South Devon Clinical Commissioning Group (CCG) issued a Serious Breach Notice to the Home. Some residents had already been removed and placed within different homes, as there were concerns for their safety. In particular, Resident C, who had poorly controlled diabetes and was at risk as staff were said not to have the knowledge to care for him.
 7. There were also concerns in relation to staff '*cutting and pasting*' care records on the electronic system using handheld devices. It is also said that multiple entries were made at the same time indicating that the same person had given care at that time, when this would not have been possible.
 8. The Home was also found to be dirty and had a strong smell of urine present. Residents were found to have been allocated to only one incontinence pad during the day and one at night for their continence needs. There were also difficulties with moving and handling, and one resident, Resident I, had been left on the floor for several hours after a fall without assistance.
 9. On 29 April 2016, the Registrant closed the Home and all the residents were found new homes.
 10. The Registrant is currently residing outside of the UK.
 11. The NMC has received and assessed all of the relevant evidence obtained during the local investigations.

12. Witness statements have been obtained from:

- Ms 1, Residential Nurse Lead
- Ms 2, Senior Social Worker
- Ms 3, Quality Assurance and Improvement Officer
- Ms 4, former Social Care Assessor
- Ms 5, CQC Inspector
- Mr 6, District Nurse
- Ms 7, former Care Assistant at the Home

13. Charges 1 to 42 set out the specifics in relation to the Registrant's failure to ensure safe and effective care of residents both as a nurse working in the Home, as well as the registered manager and provider. Charge 43 sets out the specifics in relation to the Registrant encouraging a culture of dishonest record keeping by creating multiple retrospective records and failing to regularly audit care records produced by staff in the Home.

14. The Registrant frequently acted as the only nurse on duty at the Home and so the identified matters are in relation to her own clinical practise as well as her managerial capabilities. For example, on 6 March 2016, when a carer informed the Registrant that Resident C, an insulin-dependent diabetic, could not be roused. After the Registrant examined him she returned stating "he was just playing silly buggers" (as referred to at charge 3).

15. The witness statements obtained attest to the Registrant's poor attitude and response to concerns being identified and raised to her. The witness evidence comprises a wide range of individuals who were either involved in a period of intervention within the Home, or in the case of Ms 7, were working within the environment itself. The Registrant was not accepting of the poor culture of care within the Home, the serious implications for the residents

within it and her responsibility in addressing these. Furthermore, as the Registrant was often working within a nursing capacity as part of the staff, it was not the case that she was too far removed from the day to day care provision in a management role to witness the poor care provision.

16. During a Safeguarding meeting on 10 March 2016 a number of matters were noted in relation to the record keeping within Garston Manor. This included the falsification and duplication of patient records. For example, the initials on fluid charts showed one person had given fluids to 20 people all at the same time in the same way. It was a regular occurrence and general consensus amongst staff at the Home to input data for nutrition fluids and personal care that had not taken place (as referred to at charge 24). Witness statements comment on the paper and electronic record keeping system utilised at the time and their direct observations of inaccurate records being made by staff members in relation to resident care.

17. All facts as detailed in the charges are admitted by the Registrant.

Misconduct

18. In the case of *Roylance v General Medical Council (No.2)* [2000] 1 AC 311, Lord Clyde stated that:

‘misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by the medical practitioner in the particular circumstances’.

19. The Registrant admits that her conduct fell seriously short of the standards of behaviour expected of Registered Nurses. Moreover, the Registrant accepts

that her actions breached the following paragraphs of the 2015 NMC Code of Conduct:

8 Work Cooperatively

To achieve this, you must:

- 8.2 *maintain effective communication with colleagues*
- 8.4 *work with colleagues to evaluate the quality of your work and that of the team*
- 8.5 *work with colleagues to preserve the safety of those receiving care*

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

- 9.2 *gather honest, accurate and constructive feedback to colleagues*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

- 11.2 *make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*

11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard*

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.4 *acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so*

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*

20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*

20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you*

deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

20. It is accepted that the Registrant failed to ensure safe and effective care of residents both as a nurse working in the Home, as well as the registered manager and provider. Further, the Registrant encouraged a culture of dishonest record keeping by creating multiple retrospective records and failing to regularly audit care records produced by staff in the Home. A nurse acting dishonestly in a professional capacity clearly has the potential to impact on those in their care.

21. The Registrant accepts that her failings resulted in residents at the Home receiving an extremely poor standard of care which caused actual harm to certain residents whilst placing all residents at the Home at risk of harm.

22. The Registrant accepts that the facts, individually and collectively, amount to misconduct.

Current Impairment

23. The parties have considered the questions formulated by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of *CHRE v Grant & NMC* [2011] EWHC 927 (Admin) ('*Grant*') by Cox J. They are 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.

24. The parties agree that the admitted facts do amount to the Registrant putting patients at unwarranted risk of harm and the parties also agree that the Registrant has breached fundamental tenets of the profession and has acted dishonestly. The Registrant accepts that she has brought the reputation of the nursing profession into disrepute.

25. In considering the question of whether the Registrant's fitness to practise is currently impaired, the parties have considered *Cohen v GMC* [2007] EWHC 581 (Admin), in which the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:

1. Whether the conduct that led to the charge(s) is easily remediable
2. Whether it has been remedied
3. Whether it is highly unlikely to be repeated

26. The failings in this case are wide ranging and also involve dishonest behaviour on the part of the registrant and accordingly the parties agree that such conduct would could not be described as easily remediable.

Insight

27. The Registrant has not been referred to the NMC aside from the referral which led to this case. Previous concerns had been raised locally however with regard to the practices and conditions at the Home.

28. The Registrant has provided a reflective statement for the purpose of these proceedings, received on 4 June 2019 (**Appendix 1**). In this she states:

29. *"I accept that due to my failings as a Manager, that I should no longer practice as a nurse, this is something I have accepted and even discussed with DCC as a condition that the home could no longer function. For this reasoning I believe a striking-off order would be appropriate action to take, as no matter the timeframe, I will never be mentally fit to work as a nurse again. If the panel decides otherwise, I will also accept other sanctions."*

30. The NMC accepts that the Registrant's reflective piece demonstrates an acceptance of some responsibility by the Registrant. However, her insight into the failings and the impact they had on others as well as the wider reputation of the profession is limited.

Remediation

31. It is noted that the Registrant has not been referred to the NMC aside from the matters arising in this case. The Registrant has been subject to an interim suspension order since 29 September 2016 and so has not been able to practise as a registered nurse during this time. Following her referral to the

NMC, the Registrant has stated that she has no intention to return to nursing. Accordingly, despite the Registrant providing training certificates and references in relation to her interim order hearing in September 2016 (**Appendix 2**), there is insufficient evidence that the concerns identified in this case have been adequately addressed and the risk of repetition sufficiently minimised.

32. In light of the level of the Registrant's level of insight and the lack of sufficient remediation, the risk of repetition of future misconduct of the kind found in this case is high. Therefore, a finding of current impairment is required on public protection grounds.

Impairment – public interest

33. The Registrant's failings took place over a prolonged period, putting those in her care at serious risk of harm and whilst she was in a position of trust and authority. Further the Registrant has acted dishonestly as well as contributing toward a culture of dishonesty amongst staff at the Home.

34. The parties therefore agree that this is a case where a finding of current impairment is also required to declare and uphold proper professional standards and protect the reputation of the nursing profession. This is in accordance with the comments of Cox J in *Grant* at paragraph 101:

“The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.”

35. Accordingly the parties agree that a finding of impairment is required on both public protection and public interest grounds.

Sanction

36. The appropriate sanction in this case is a striking-off order. The parties considered the NMC Sanctions Guidance, bearing in mind that it provides guidance not firm rules.

37. The aggravating features of the case are as follows:

- The Registrant was in a senior position of trust/authority and failed in her duties of care for vulnerable residents
- The failings took place over an extended period of time

38. The mitigating features of the case are as follows:

- The Registrant has shown some insight and acceptance into her failings

39. In considering what sanction would be appropriate the parties began by considering whether this is a case in which it would be appropriate to take no further action. The parties agree that this would leave the public exposed to an unwarranted risk of harm, given there remains a risk of repetition of the misconduct. The parties also agreed that this would not be a sufficient course of action to address the public interest considerations in this case.

40. The parties next considered whether a caution order would be appropriate. A caution order would not restrict the Registrant's practice and would therefore be insufficient to protect the public given the risk of repetition of the misconduct. The parties also agree that such a sanction would not be sufficient to maintain public confidence.

41. The parties considered the imposition of a conditions of practice order. The parties agree that there are wide ranging failings including dishonesty in this case which are not easily remediable. In weighing all of the information before it, the parties agree that it could not formulate workable conditions of practice and that conditions would not provide sufficient protection to the public. In addition, the parties agree that the wider public interest would not be satisfied by the imposition of a conditions of practice order.
42. The parties also agree that, in light of the level of the misconduct in this case and the associated public interest concerns, a sanction preventing the registrant from practising is currently required.
43. The parties considered whether a period of temporary removal from the register would adequately mark the Registrant's conduct. The parties kept in mind the wide range, seriousness and duration of these failings. The allegations are serious and wide ranging. The Registrant was in a senior position and failed in her duties to care for vulnerable residents. Residents at the Home were left on the floor for hours after a fall and the staff who were employed at the Home did not have the adequate training to care for their needs. While the Registrant does show some insight, she does not seem to acknowledge the seriousness of the failings nor does she fully accept the charges relating to dishonesty.
44. The parties agree that a suspension order would not be sufficient to mark the seriousness of the misconduct and the grave extent to which the Registrant departed from the standards to which she was expected to adhere as a member of the nursing profession.
45. Accordingly the parties agree that the only appropriate sanction in this case is a striking off order. The Registrant acted in a way which runs contrary to the

values of the nursing profession and the facts behind the misconduct would be considered deplorable. The parties agree that a striking off order will ensure that public confidence in the nursing profession is maintained.

46. Finally, the parties agree that an interim order is required in this case. The order is necessary for the protection of the public and is otherwise in the public interest (for the reasons given above). The order should be for a period of 18 months to guard against the risk to the public in the event that the Registrant seeks to appeal against the substantive order. The interim order should take the form of an Interim suspension order.

47. The parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings of impairment and sanction is a matter for the panel. The parties also understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegations, provided that it would be relevant and fair to do so.”

Here ends the provisional agreement between the NMC and Mrs Parkhouse. The provisional agreement was signed by Mrs Parkhouse on 12 August 2019 and the NMC on 27 August 2019.

Decision and reasons on the consensual panel determination

The panel today decided to accept the consensual panel determination.

The panel heard and accepted the legal assessor's advice. She referred the panel to the NMC Sanctions Guidance (SG) and to the NMC's guidance on Consensual Panel Determinations. She reminded the panel that they could accept, amend or outright reject the provisional agreement reached between the NMC and Mrs Parkhouse. Further, the panel should consider whether the provisional agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Mrs Parkhouse admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Mrs Parkhouse's admissions as set out in the signed provisional agreement before the panel.

The panel then went on to consider whether Mrs Parkhouse's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mrs Parkhouse, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel determined that the allegations were serious, wide ranging and covered a significant time period whilst she was the manager of the Home between 2012 and 2016. The panel noted that there were a number of substantial clinical failings in regard to Mrs Parkhouse's conduct. In this respect the panel endorsed paragraphs 18 to 22 of the provisional agreement in respect of misconduct.

The panel then considered whether Mrs Parkhouse's fitness to practise is currently impaired by reason of her misconduct. The panel determined that Mrs Parkhouse's fitness to practise is currently impaired, as it was evident that there was a risk to patient

safety and the wider public interest if Mrs Parkhouse was permitted to practise unrestricted. In addition, Mrs Parkhouse herself accepts that her fitness to practise is currently impaired. In this respect the panel endorsed paragraphs 23 to 35 of the provisional agreement.

The panel considered that whilst it might be in the public interest to hear Mrs Parkhouse's case in public, it found that it was more effective to expeditiously dispose of Mrs Parkhouse's case today. The panel noted she has returned to live in Chile and has clearly stated that she does not wish to continue practising as a registered nurse in the UK. Therefore, the panel determined it was not in the public interest to delay these matters by taking them forward to a hearing.

Having found Mrs 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.

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 Parkhouse off the register. The effect of this order is that the NMC register will show that Mrs 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. The panel accepted the advice of the legal assessor. 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 Sanctions Guidance ("SG") published by the NMC and considered the aggravating and mitigating factors. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

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

Next, in considering 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 and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Parkhouse's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Parkhouse's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the wide ranging nature of the proven facts. The serious misconduct and dishonesty identified in this case is not something that can be addressed through retraining.

Furthermore the panel concluded that placing conditions on Mrs Parkhouse's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel noted the mitigating factors include the personal circumstances Mrs Parkhouse was dealing with at the time of the misconduct and her admissions as to the facts.

The aggravating factors that the panel took into account, in particular, are the actual and potential patient harm, and the lack of insight demonstrated by Mrs Parkhouse, raising the issue of potential repetition.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

Balancing all of these factors, the panel has determined that a suspension order would not be an appropriate or proportionate sanction.

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

Mrs Parkhouse's actions were a serious breach of the fundamental tenets of the nursing profession which 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 her actions were so serious that 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, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mrs 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 this would be sufficient in this case.

The panel 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

The panel determined that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.