Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting
Monday, 24 June 2024 – Wednesday, 26 June 2024

Virtual Meeting

Name of Registrant:	**Konrad Joseph Migraso**
NMC PIN:	21I0888O
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 - 15 September 2021
Relevant Location:	Hull
Type of case:	Lack of competence
Panel members:	Simon Banton (Chair, Lay member) Anne Considine (Registrant member) James Kellock (Lay member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Eleanor Wills
Facts proved:	Charges 1.1, 1.2, 2.1, 2.2, 2.4, 3.1, 3.2, 4.1, 5.1, 6.1, 6.2, 6.3, 7.1, 7.2, 7.3, 8, 9.1, 9.2, 9.3, 9.4, 9.5, 9.6, 9.7, 9.8, 10.1, 10.2
Facts not proved:	Charges 2.3
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel took into account that the Notice of Meeting had been sent to Mr Migraso's email address by secure email on 17 May 2024.

The notice was sent to an email address which was not Mr Migraso's email address registered on Wiser. However, the panel was provided with a chain of emails between the NMC and Mr Migraso, to and from this email address and the panel inferred from this that Mr Migraso's use of this email address in corresponding with the NMC, indicated that he was content for it to be used for service of the Notice of Meeting.

Further, the panel took into account that the Notice of Meeting was also sent to Mr Migraso's representative at the Royal College of Nursing (RCN) on 17 May 2024.

The panel accepted the advice of the legal assessor and had regard to Rule 34(3)(b) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel took into account that the Notice of Meeting provided details of the allegations, the time and date for this meeting to take place.

In the light of all the information available, the panel was satisfied that Mr Migraso has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34.

Decision and reasons to amend the charges

The panel of its own volition made amendments to the charges:

The introductory line to replace the word *'September'* for the word *'March'*.

> 'That you, a registered nurse, while working for the Hull University Teaching Hospitals NHS Trust at the Hull Royal Infirmary Hospital between 15 ~~March~~

September 2021 and 11 August 2022 did not meet the standards required of a Band 5 nurse in that:'

The panel had regard to the fact that Mr Migraso registered as a nurse with the NMC on 15 September 2021. The panel determined that the amendment would better reflect the evidence. The amendment was in the interests of justice. There would be no prejudice to Mr Migraso and no injustice would be caused to either party by the proposed amendment being allowed as there was no material change to the substance of the charges.

Charge 1a, to replace the word *'elevated'* with the word *'low'* and to insert the word *'elevated'* before the word *'heart'.*

'1) On 4 November 2021 you:

1.1 Did not identify Patient A's ~~elevated~~ **low** blood pressure and **elevated** heart rate during clinical observations.'

The panel had regard to the fact that, at the relevant time, Patient A's blood pressure was 81/54, which is categorised as low and their heart rate was 104 bpm, which is categorised as high. The panel determined that the amendment would better reflect the evidence. The amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Migraso and no injustice would be caused to either party by the proposed amendment being allowed as there was no material change to the substance of the charges.

In reaching its decision the panel had regard to Rule 28 and accepted the advice of the legal assessor.

Details of charges as amended

That you, a registered nurse, while working for the Hull University Teaching Hospitals NHS Trust at the Hull Royal Infirmary Hospital between 15 September 2021 and 11 August 2022 did not meet the standards required of a Band 5 nurse in that:

1) On 4 November 2021 you:

1.1 Did not identify Patient A's low blood pressure and elevated heart rate during clinical observations.

1.2 Did not escalate concerns regarding Patient A appropriately or at all.

2) On 20 January 2022 you:

2.1 Did not identify a change in Patient B's breathing.

2.2 Did not escalate concerns regarding Patient B appropriately or at all.

2.3 Did not administer IV fluids without prompting from Colleague B.

2.4 Did not take a blood pressure reading without prompting from Colleague B.

3) On 17 March 2022 you:

3.1 Did not communicate with Patient C in an appropriate manner in that you:

3.1.1 Repeatedly offered to assist Patient C with her morning care despite Patient C indicating she had capacity to carry this out herself.

3.2. Did not provide a commode to Patient D despite their repeated requests.

4) On an unknown date in June 2022 you:

4.1 Did not correctly monitor and/or manage Patient E's blood glucose levels.

5) On 29 June 2022 you:

5.1 Fed porridge to Patient H after being informed that they were to be fed nil by mouth.

6) On 8 July 2022 you:

6.1 Required prompting when administering medication by a supervisor.

6.2 Did not escalate concerns regarding Patient I appropriately or at all.

6.3 Required prompting to record Patient I's vital signs.

7) On 20 July 2022 you:

7.1. Laughed and walked away without explanation when speaking to a colleague regarding a patient's belongings.

7.2. Threw linen covered in faeces on the floor in the presence of a patient and their relative.

7.3 Did not clean up the linen from the floor in a timely manner when requested to do so.

8) You were not signed off as competent in medications management and administration.

9) You did not complete the following training:

9.1 Information Governance
9.2 Moving and Handling (Clinical)
9.3 Fire Safety (Clinical)
9.4 Resuscitation
9.5 Tissue Viability- Registered
9.6 Dementia (Tier 2)
9.7 Moving and Handling (Non-Clinical)
9.8 Fire Safety (Non-Clinical)

10) You did not fully complete the development action plans set:

10.1 On 26 August 2021.
10.2 On or around 14 March 2022.

AND in light of the above, your fitness to practise is impaired by a lack of competence.

Background

Mr Migraso is a Registered Adult Nurse who joined the NMC's register on 15 September 2021.

Mr Migraso was referred to the NMC on 26 August 2022 by the Hull University Teaching Hospitals NHS Trust ('the Trust'). He undertook a probationary period with the Trust as a Band 5 Staff Nurse between 15 September 2021 and 11 August 2022. During this probationary period, concerns were raised about his competence to practise as a Registered Nurse. Some of the primary concerns raised by the Trust were in respect of:

- Medication administration and management;
- Escalation of deteriorating patients;

- Communication with colleagues and patients; and
- Failure to complete mandatory training

In addition to generalised concerns raised during the course of Mr Migraso's employment, there were several specific incidents of concern raised by the Trust which are reflected in the charges.

Decision and reasons on facts

In reaching its decisions on the facts, the panel considered all the documentary information before it together with the written representations made by the NMC. Mr Migraso had not responded to the Case Management form sent with the Notice of Meeting and the panel concluded that no formal admissions had been made in respect of any of the charges.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Band 7 Registered Nurse employed as a Senior Ward Sister by the Trust, at the time of the allegations.
- Witness 2: Registered General Nurse employed as a Junior sister by the Trust, at the time of the allegations.
- Witness 3: Registered Nurse employed by the Trust as a Charge Nurse, at the time of the allegations.

The panel also had regard to previous written responses from Mr Migraso's representative.

Before making any findings on the facts, the panel accepted the advice of the legal assessor.

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

Charge 1

'That you, a registered nurse, on 4 November 2021:

1.1 Did not identify Patient A's low blood pressure and elevated heart rate during clinical observations.

1.2 Did not escalate concerns regarding Patient A appropriately or at all.'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraphs 45-49. The panel considered the *'P File Note'* dated 4 November 2021, signed by Witness 1.

> *'Konrad was asked to complete some clinical observations …On returning to the ward it was noted that one of the patients had NEWs score of 4 due to a BP of 81/54 AND HR of 104, when discussing with the doctor and the NIC this has not been escalated to them.*
>
> *I spoke with Konrad regarding this patient and he advised he had escalated the NEWs score to me, however this was impossible as I was off the ward at a meeting at the time the observations were completed.*
>
> *I reminded Konrad that any patients who are deteriorating must be escalated to the doctor and the NIC.'*

The panel took into account the management report dated 11 August 2022 and the timeline of events from 15 March 2021 to 20 July 2022 and had specific regard to the entry on 4 November 2021.

The panel determined that, in the light of the contemporaneous *'P File Note'* dated 4 November 2021 and the corroborating consistent and detailed account provided by Witness 1, charge 1 in its entirety is found proved.

Charge 2.1, 2.2, 2.4

'That you, a registered nurse, on 20 January 2022:

2.1 Did not identify a change in Patient B's breathing.

2.2 Did not escalate concerns regarding Patient B appropriately or at all.

2.4 Did not take a blood pressure reading without prompting from Colleague B.'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraphs 63-67. The panel considered the *'P File Note'* dated 24 January 2021, signed by Witness 1 and the written statement of Colleague B dated 24 January 2022 provided by Witness 1.

> *'Whilst they was (sic) turning bed 3/2 it was the auxiliary nurse that came to myself and asked if patient was for resus as his breathing had changed. I then went to assess the patient myself and found him to be breathing very shallow. Konrad was just stood at the bedside and made no attempt to escalate the situation. I felt he needed asking to complete observations and then more so act on the results...but again Konrad needed prompting to re take observations to check if fluids was (sic) bringing the Bp (sic) up.'*

The panel considered Mr Migraso's reflection on the alleged incident.

‘My personal issues as noticed by my senior nurse, was that I did not made (sic) the immediate escalation the moment I noticed the patient’s condition.

…

… I failed so much in making prompt initial nursing action during that particular case.

I failed to follow the pathway. I had not taken his vitals observation as EWS policy required. Another thing to consider, the medical doctor should be informed.’

The panel determined that, in the light of the contemporaneous statement of Colleague B, Mr Migraso’s partial admissions and the corroborating account of Witness 1, charges 2.1, 2.2 and 2.4 are found proved.

Charge 2.3

‘That you, a registered nurse, on 20 January 2022:

c. Did not administer IV fluids without prompting from Colleague B’

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statement of Colleague B dated 24 January 2022 and provided by Witness 1.

‘My colleague and I did BM and put IVI (sic) up but again Konrad needed prompting to re take observations to check if fluids was (sic) bringing the Bp (sic) up.’

The panel determined that Colleague B and another colleague administered IV fluids NOT Mr Migraso. Mr Migraso needed prompting to undertake observations but he himself did not administer IV fluids. The panel therefore concluded charge 2.3 is found NOT proved.

Charge 3

‘That you, a registered nurse, on 17 March 2022:

3.1 Did not communicate with Patient C in an appropriate manner in that you:

3.1.1 Repeatedly offered to assist Patient C with her morning care despite Patient C indicating she had capacity to carry this out herself.

3.2 Did not provide a commode to Patient D despite their repeated requests.’

This charge is found proved.

In reaching this decision, the panel took into account Witness 1’s statement signed and dated 27 April 2023 and had specific regard to paragraphs 72 and 73. It also took into account Witness 2’s statement signed and dated 25 March 2023 and had specific regard to paragraphs 8-14. The panel considered the email from Witness 2 to Witness 3 dated 6 April 2022.

> *‘On the 17th of March… Konrad offered to help a female patient to do her morning care but the patient declined as she is well enough to do it. After that he still tried to offer help to the patient a few times even though patient clearly asked him not to. Patient became unhappy and told him to leave her alone...Another incident happened the same day when a patient asked for a commode from Konrad but he failed to bring one. Patient waited and had to ask another staff for a commode.’*

The panel determined that, given the near contemporaneous report regarding charge 3, contained in an email from Witness 2 to Witness 3 dated 6 April 2022, charge 3 in its entirety is found proved.

Charge 4

‘That you, a registered nurse, on an unknown date in June 2022:

4.1 Did not correctly monitor and/or manage Patient E’s blood glucose levels.’

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraph 86. The panel considered the feedback form for Mr Migraso completed by his supervisor at the time, Colleague C, for June 2022.

> *'a patient who was a (sic) insulin dependent diabetic had low CBG [blood glucose]. I had to take charge of the situation, and delivering and monitoring the care given to the patient. At this point in Konrad's development, I would have expected him to take charge in delivering and monitoring the patient…'*

Further the panel had regard to Mr Migraso's reflection on the experience contained in the feedback form.

> *'Patient with low blood glucose reading needs prompt action.'*

The panel determined that, in the light of what appeared to be contemporaneous feedback from in which Colleague C provided a clear and cogent account and the fact that Mr Migraso acknowledged the need to take prompt action when a patient has low blood glucose levels, charge 4 is found proved.

Charge 5

> 'That you, a registered nurse, on 29 June 2022:
>
> 5.1 Fed porridge to Patient H after being informed that they were to be fed nil by mouth.'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraph 62. The panel considered the timeline of events from 15 March 2021 to 20 July 2022, and had specific regard to the entry on 29 June 2022.

'…Konrad had been informed that a dementia patient was nil by mouth awaiting a procedure …

The patient had requested porridge for breakfast and Konrad was observed feeding the patient. [Witness 1] was informed of the incident by the practice supervisor, who then asked Konrad why he had fed the patient. Konrad replied that it was because the patient had requested it. [Witness 1] informed Konrad that the patient had a cognitive impairment and asked Konrad if he was aware that the patient was having a procedure later in the day. Konrad replied that he was aware and that the patient was nil by mouth.'

Further in the management report dated 11 August 2022, reference was made to the alleged incident.

'Konrad was also observed feeding a patient with cognitive impairment who was nil by mouth. Konrad stated that he knew the patient was nil by mouth but proceeded to feed him anyway.'

There were not before the panel records of feedback dated 22 June 2022–29 June 2022 as referred to in the management report dated 11 August 2022. However, it determined that the account provided by Witness 1 was clear and consistent. It therefore found charge 5 proved.

Charge 6

'That you, a registered nurse, on 8 July 2022:

6.1 Required prompting when administering medication by a supervisor.

6.2 Did not escalate concerns regarding Patient I appropriately or at all.

6.3 Required prompting to record Patient I's vital signs.'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraph 86. The panel considered the

feedback form for Mr Migraso completed by his supervisor at the time, Colleague D, on 8 July 2022.

> *'I supervised a medication round in which I feel Konrad has made little to no progress. Had I not prompted him several medications for one of the patients would have been missed as he failed to scroll down the page on EPMA.'*

The panel also had regard to Mr Migraso's reflection on the experience contained in the feedback form.

Further the panel took into account the timeline of events from 15 March 2021 to 20 July 2022 and had specific regard to the entry dated 8 July 2022.

> *'Konrad required prompting when distributing medication and one patient would have been missed completely had Konrad not been prompted by his supervisor. Konrad stated that he had escalated a patient but it was identified that an auxiliary nurse had in fact escalated the concern to the supervisor …Konrad was sked (sic) to check vital signs and record on EOBS. The supervisor felt that without this prompt Konrad would have failed to record these vital signs.'*

The panel determined that, in the light of the contemporaneous feedback form in which Colleague D provides clear and cogent evidence and the detailed timeline of events, on the balance of probabilities charge 6, in its entirety, is found proved.

Charge 7

'That you, a registered nurse, on 20 July 2022:

7.1 Laughed and walked away without explanation when speaking to a colleague regarding a patient's belongings.

7.2 Threw linen covered in faeces on the floor in the presence of a patient and their relative.

7.3 Did not clean up the linen from the floor in a timely manner when requested to do so.'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraphs 96-100. The panel considered an email from Colleague E to Witness 1 dated 22 July 2022.

> *'When I came out of the treatment room, one of the transport team said to me "What's his problem?" and he pointed to Konrad. I asked what the problem was and he said he had asked Konrad to get this patients belongings packed and he had laughed at him and walked off.*
>
> *…Konrad had thrown the bedding with faeces on (sic) onto the floor, whilst patients were eating. Straightway I said to him to get the bedding removed and not to throw it onto the floor. He then preceded (sic) to throw something in the bin and I again told him to get the dirty linen removed from the floor. There was no urgency demonstrated from him at all despite me asking twice and then had to tell him for a 3rd time.'*

The panel had regard to the *'P File note'* written by Witness 1 following the complaint raised by Colleague E on the 20 July 2022.

The panel determined that, in the light of the contemporaneous email from Colleague E to Witness 1 and the corroborating clear and consistent account provided by Witness 1, charge 7, in its entirety, is found proved.

Charge 8

> 'That you, a registered nurse, were not signed off as competent in medications management and administration.'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraphs 28, 39, 42, 55 and 95. The panel considered the feedback form for Mr Migraso completed by his supervisor at the

time, Colleague D, on 8 July 2022. The panel had regard to the documentation of Mr Migraso's mid probationary review meeting dated 1 November 2021 and final probationary review meeting dated 5 January 2022. The panel took into account that there was a mandatory requirement for Mr Migraso to be signed off as competent in medication administration and management by June 2021 and determined that this remains outstanding.

The panel therefore determined that charge 8 is found proved.

Charge 9

'That you, a registered nurse, did not complete the following training:

9.1 Information Governance
9.2 Moving and Handling (Clinical)
9.3 Fire Safety (Clinical)
9.4 Resuscitation
9.5 Tissue Viability- Registered
9.6 Dementia (Tier 2)
9.7 Moving and Handling (Non-Clinical)
9.8 Fire Safety (Non-Clinical).'

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's supplementary statement signed and dated 20 February 2024 and had specific regard to paragraphs 4-5, in which she stated that *'During Mr Migraso's employment, he was required to complete some mandatory training… I exhibit Mr Migraso's mandatory training… which includes the courses that Mr Migraso was required to complete and those courses which he failed to complete.'* The panel had regard to Mr Migraso's mandatory training record and noted that it stated that Mr Migraso had not completed the following training programmes:

- Information Governance
- Moving and Handling (Clinical)
- Fire Safety (Clinical)

- Resuscitation
- Tissue Viability- Registered
- Dementia (Tier 2)
- Moving and Handling (Non-Clinical)
- Fire Safety (Non-Clinical).

The panel determined that, in the light of the contemporaneous record of Mr Migraso's mandatory training and the corroborating evidence of Witness 1, charge 9, in its entirety, is found proved.

Charge 10

'That you, a registered nurse, did not fully complete the development action plans set:

10.1 On 26 August 2021.

10.2 On or around 14 March 2022.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement signed and dated 27 April 2023 and had specific regard to paragraphs 77.

In relation to charge 10a, the panel took into account the letter to Mr Migraso from Witness 1 dated 1 September 2021, and the notes from the review meeting dated 26 August 2021 and the accompanying agreed action plan. The panel had regard to the documentation of the mid probationary review meeting dated 1 November 2021 and final probationary review meeting dated 5 January 2022 and determined that Mr Migraso had not fully completed the development action plan set on 26 August 2021.

In relation to charge 10b, the panel took into account Witness 3's statement signed and dated 31 March 2023 and had regard to paragraphs 18-46, specifically paragraph 45 in which it was detailed clearly which parts of the action plan Mr Migraso completed and which he did not. The panel considered the action plan dated 14 March 2022 and the

email from Witness 3 to Witness 1 dated 18 April 2022 and determined that Mr Migraso has not fully completed the development action plan set on 14 March 2022.

The panel therefore determined that, in the light of the clear and detailed contemporaneous documentary evidence, charge 10, in its entirety, is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Mr Migraso'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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Mr Migraso's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

The NMC invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Mr Migraso's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Mr Migraso was made aware of the issues around his competence?
- Is there evidence that Mr Migraso was given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mr Migraso's competence at the time was below the standard expected of a band 5 Registered Nurse.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC provided the following written representations regarding impairment of fitness to practise.

> *'Public protection*
>
> *54.Looking at the first question from the Shipman Report, the NMC submits that Mr Migraso's actions as outlined in the charges clearly placed patients at risk of harm, as further summarised at paragraph 46 above.*
>
> *55.However, impairment is a forward-thinking exercise that looks at past events to help assess future risk. The NMC's guidance on impairment ('DMA-1') adopts the*

approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking whether the concern is easily remediable, whether it has in fact been remedied, and whether it is highly unlikely to be repeated. In essence the key question posed is whether Mr Migraso has acted, or is liable in the future to act, so as to put a patient or patients at unwarranted risk of harm.

56.The NMC acknowledges that, as these concerns relate to issues of competency, there does not appear to be evidence of deep-seated attitudinal concerns. It would therefore be possible for Mr Migraso to address the issues raised by demonstrating insight into the concerns, and showing he has taken steps to address the concerns raised through training, supervised practice, or other work, so that he is now able to practice safely and independently.

57.However, at this time, the NMC submits that Mr Migraso has not demonstrated he has addressed the concerns raised. He has not provided any formal response to the charges to show any level of insight into the seriousness of the concerns raised, and has provided no evidence of recent training or work to address any issues with his practice.

58.While it is acknowledged that previously Mr Migraso has provided information from his employer to show some work he has done supervised as a senior carer, the NMC submits that there is very limited evidence of working in a registered capacity, and no up to date evidence of insight.

59.In light of the lack of up-to-date evidence of remediation and insight from Mr Migraso the NMC submits, at this time and without restriction, Mr Migraso is liable to place patients at unwarranted risk of harm.

60.The NMC therefore submits a finding of impairment is needed to protect the public.

Public interest

61.The NMC submits that Mr Migraso's actions in line with charges 1-10 fall so far below the standards expected of a band 5 nurse that they have the potential to undermine public confidence in the profession, and bring the profession into disrepute in line with the second question from the Shipman Report.

…

64.The NMC submits that the breaches of the Code by Mr Migraso amount to breaches of fundamental tenets of the profession in line with the third question of the Shipman Report.

…

67.In this instance the NMC submits, given such fundamental issues with Mr Migraso's competence were raised throughout his employment with the Trust, and given he has provided no up to date evidence of insight and remediation, a finding of impairment is needed to uphold public confidence in the profession and the NMC as a regulator.'

The panel accepted the advice of the legal assessor.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. The panel determined that the facts found proved breached the following terms of the Code.

'1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion.

1.2 make sure you deliver the fundamentals of care effectively.

1.4 make sure that any treatment, assistance, or care for which you are responsible is delivered without undue delay.

2 Listen to people and respond to their preferences and concerns

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care.

2.5 respect, support and document a person's right to accept or refuse care and treatment.

2.6 recognise when people are anxious or in distress and respond compassionately and politely.

4 Act in the best interests of people at all times

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment.

6 Always practise in line with the best available evidence

6.2 maintain the knowledge and skills you need for safe and effective practice.

8 Work co-operatively

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate.

8.2 maintain effective communication with colleagues.

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff.

8.6 Share information to identify and reduce risk.

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

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance.

13 Recognise and work within the limits of your competence

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly.

20 Uphold the reputation of your profession at all times

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

When reaching its decision the panel bore in mind that Mr Migraso should be judged by the standards expected of a Registered band 5 Nurse and not by any higher or more demanding standard.

The panel considered whether the charges related to a *'fair sample'* of Mr Migraso's practice. The panel took into account the concerns regarding Mr Migraso's practice arose during his probationary period with the Trust, from 15 September 2021 to 11 August 2022. Specified incidents occurred in November 2021, January 2022, March 2022, June 2022 and July 2022. Moreover, the incidents were varied in their nature and there were many witnesses to his failings. The panel determined that the charges found proved represent competency issues in a number of areas over an extended period of time and therefore they are a *'fair sample'* of Mr Migraso's practice.

The panel determined that Mr Migraso was made aware of the issues regarding his competency and was provided with the opportunity to improve his practice. The Trust extended the period of his probation more than once and provided him with support and supervision. The Trust also reallocated Mr Migraso to a different ward to determine if the cohort of patients, he was treating at that time, affected his competency. However, Mr Migraso was still not reaching the required standards 11 months after probation had started and it was determined by the Trust that Mr Migraso remained unsafe when practising unsupervised. The panel had regard to the fact that during Mr Migraso's supervision his competence was criticised not by any one particular staff member but by a number of colleagues.

The panel concluded that the facts found proved are serious and wide-ranging involving in failings in his competency in medication administration and management, communication

issues, basic hygiene issues and not monitoring and escalating patients' conditions appropriately or at all.

The panel determined Mr Migraso's practice was of an unacceptably low standard and posed a potential risk of significant harm to patients as the facts found proved related directly to his ability to practice safely, kindly and effectively. The panel had specific regard to charges 1, 2.1, 2.2, 2.4, 3, 4, 5, 6 and 8.

The panel therefore concluded that Mr Migraso's practice was below the standard expected of a band 5 Registered Nurse.

In all the circumstances, the panel determined that Mr Migraso's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mr Migraso's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not 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 *CHRE v NMC and 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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. *…'*

The panel determined that the "test" was engaged on limbs a, b and c.

The panel concluded that patients were put at risk of significant harm as a result of Mr Migraso's lack of competence. Mr Migraso's lack of competence had breached the

fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel took into account Mr Migraso's previous contemporaneous reflections provided to the Trust in his feedback forms but found them limited, in their scope and his understanding of the events that had taken place. The panel had regard to the fact that it has not been provided with any up-to-date reflection by him. The panel determined that Mr Migraso has not demonstrated an understanding of how his actions put patients at a risk of harm. Nor has he demonstrated an understanding of how or why what he did was wrong and how this impacted negatively on the reputation of the nursing profession. There is no evidence to support that he has an understanding of the actual root cause of his failings. Further Mr Migraso has not demonstrated what he would do differently in the future he had simply acknowledged that he needs to do better. The panel therefore determined that Mr Migraso's insight is extremely limited.

Although Mr Migraso was provided with supervision and support by the Trust repeated incidents demonstrating his lack of competency occurred. The panel took into account that on 25 April 2023 the NMC received a report from Mr Migraso's employer at that time stating that he was employed by them as a senior carer and there was no criticism of his practice in this role. However, there is no up-to-date information regarding Mr Migraso's current employment. The panel determined that Mr Migraso's failings are potentially remediable. In its consideration of whether Mr Migraso has taken steps to strengthen his practice, the panel took into account that it does not have any evidence before it of any relevant training or remedial steps undertaken or any further reflection since his departure from the Trust.

The panel determined that there is a risk of repetition given the lack of evidence of Mr Migraso's current insight and remediation. 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 objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 was required as a well-informed member of the public would be very concerned if Mr Migraso were allowed to practice unrestricted, given his repeated and wide-ranging failings to meet the required competency expected of a band 5 Registered Nurse. Further the public confidence in the profession and the NMC would be undermined if Mr Migraso were allowed to practice unrestricted.

Having regard to all the above, the panel was satisfied that Mr Migraso's fitness to practise is currently impaired.

Sanction

The panel has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mr Migraso's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

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

Representations on sanction

The NMC provided the following written representations regarding sanction.

> *'68. The NMC considers the appropriate and proportionate sanction in this case to be a conditions of practice order for a period of 12-months with a review before expiry.*
>
> *69. The aggravating features of this case are:*
>
> *69.1 Repeated errors despite appropriate additional support;*

69.2 Concerns relating to fundamental areas of Mr Migraso's competency;

69.3 Potential for patient harm; and

69.4 Lack of insight and remediation.

70. The mitigating factors in this case include:

70.1 Support from his current employer where he is working as a senior carer.

71. Considering the facts of this case in line with the available sanctions in ascending order of seriousness:

No action/caution order

72. The NMC's guidance on taking no further action ('SAN-3a') and caution orders ('SAN-3b) indicates that these options would not be appropriate where there is a potential risk to the public. In this case, given that fundamental concerns have been raised in respect of Mr Migraso's competency, and patients have been placed at risk through his past conduct, the NMC submits imposing no order or a caution order would not be sufficient to protect the public, or maintain confidence in the profession and the NMC as a regulator.

Conditions of Practice Order

73. The NMC's guidance on conditions of practice orders ('SAN-3c') states that a conditions of practice order may be appropriate when factors are present including:

73.1 No evidence of harmful deep-seated personality or attitudinal problems;

73.2 Identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining;

73.3 Potential willingness to respond positively to retraining;

73.4 Patients will not be put in danger either directly or indirectly as a result of the conditions;

73.5 The conditions will protect patients during the period they are in force; and

73.6 Conditions can be created that can be monitored and assessed.

74.In this instance the NMC submits Mr Migraso's lack of competence does not indicate harmful deep-seated personality or attitudinal problems; there are clear and identifiable areas of Mr Migraso's practice which can be addressed by assessment and retraining; given positive references from the Home there is a potential willingness to respond positively to retraining; if conditions are appropriately drafted any public protection concerns can be addressed; and conditions can be created which can be appropriately monitored and assessed.

…

Suspension Order

76.NMC guidance on suspension orders ('SAN-3d') outlines that a suspension order may be appropriate in cases "where the misconduct isn't fundamentally incompatible with the nurse, midwife or nursing associate continuing to be a registered professional, and [the NMC's] overarching objective may be satisfied by a less severe outcome than permanent removal from the register."

77.The guidance also outlined that one of the key considerations before imposing a suspension order is "Whether the seriousness of the cases require[s] temporary removal from the register?"

78.The NMC submits that, while a suspension order would provide a sufficient level of public protection, and would address wider public interest concerns, it would be disproportionate in the circumstances given Mr Migraso's lack of competence could be appropriately addressed through a conditions of practice order.

79.A suspension order would also prevent Mr Migraso from being able to fully address the competency concerns raised through safe and monitored practice.

Striking-off order

80.Article 29(6) of the Nursing and Midwifery Order 2001 confirms that a striking off order may not be made where a registrant has been found impaired by reason of a lack of competence "unless the person concerned has been continuously suspended or subject to a conditions of practice order, for a period of no less than two years immediately proceeding the date of the decision of the Committee to make such and order."

81.As Mr Migraso has not been subject to a substantive suspension or conditions of practice order for two years, a striking-off order is not available to the Panel for the purposes of this meeting.'

Decision and reasons on sanction

Having found Mr Migraso'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:

- Extremely limited insight into failings.
- Conduct which put patients at risk of suffering harm.
- No evidence of strengthening of practice.

The panel considered whether there was any evidence of mitigation and determined that there was none before it at this time.

The panel first considered whether to take no action but concluded that this would be inappropriate in the light of Mr Migraso's unacceptably low standard of practice which put patients at risk of harm on numerous occasions over an extended period of time. The

panel decided that it would not be proportionate to take no further action. Further it would not sufficiently protect the public nor adequately address the public interest.

It then considered the imposition of a caution order but again determined that, due to the public protection issues identified, an order that does not restrict Mr Migraso's practice would not be appropriate in the circumstances. The SG 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 Mr Migraso's lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would not be proportionate given Mr Migarso's unacceptably low standard of practice, his extremely limited insight and the lack of evidence of strengthening of his practice. Further the panel determined that a caution order would not be sufficient to protect the public or to adequately address the public interest.

The panel next considered whether placing conditions of practice on Mr Migraso'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 took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that these incidents are specific and are related to identifiable areas of Mr Migraso's practice. The panel determined that Mr Migraso's failings

are remediable. The panel also took into account that conditions would allow Mr Migraso the opportunity to strengthen his clinical practice as a Registered Nurse. The panel determined that conditions were sufficient to address the public protection issues identified and mitigate the public interest concerns. Further it is in the public interest that, with appropriate safeguards, Mr Migraso should be able to return to practise as a Registered Nurse.

The panel was mindful that it does not have any up-to-date information regarding Mr Migraso's current employment or his willingness to comply with conditions, given his lack of engagement. However, the panel was of the view that due to the nature of the charges found proved, a suspension order at this time is not proportionate nor appropriate as a less restrictive sanction is sufficient to meet the public protection concerns identified and the public interest.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a Registered Nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must not be the nurse in charge of any shift.

2. You must ensure that you are supervised any time you are working. Your supervision must consist of working at all times on the same

shift as, but not always directly observed by, another registered nurse.

3. You must not administer medication at any time without direct supervision until you have been deemed competent to do so by your supervisor who must be another registered nurse.

4. You will provide proof to your case officer within seven days of being signed off as competent by your supervisor in medication administration.

5. You will work with your designated manager, mentor or supervisor to create a personal development plan (PDP). Your PDP will address the concerns about:
   - clinical observations
   - communication
   - escalating deteriorating patients
   - medication administration

6. You will:
   a) Send your case officer a copy of your PDP within two months of these conditions becoming effective.
   b) Send your case officer a report from your designated manager, mentor or supervisor every three months after these conditions become effective. This report will show your progress towards achieving the aims set out in your PDP.

7. You must meet every month with your designated manager, mentor or supervisor to discuss your performance in the following areas of concern:
   - clinical observations
   - communication
   - escalating deteriorating patients
   - medication administration

8. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

9. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

10. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

11. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

12. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for a period of 12 months in order to provide Mr Migraso with the opportunity to demonstrate strengthening of his practice.

Before the end of the period of the order, a panel will hold a review to see how well Mr Migraso has complied with the order. At the review the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mr Migraso's engagement and/or attendance at any future hearing
- A reflective piece, demonstrating Mr Migraso's insight into his failings and how they put patients at a potential risk of harm and impacted the public's confidence in the profession.
- Evidence of any strengthening of practice
- Evidence of any remedial steps Mr Migraso's has undertaken to address his lack of competency in:
  • clinical observations
  • communication
  • escalating deteriorating patients
  • medication administration
- Evidence of Continued Professional Development ('CPD')

This will be confirmed to Mr Migraso in writing.

Interim order

As the conditions of practice 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 Mr Migraso's own interests until the substantive conditions of practice order takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account the following written representations provided by the NMC.

> *'Interim Order Consideration*
>
> *82.If a finding is made that Mr Migraso's fitness to practise is impaired, and a restrictive sanction is imposed, the NMC considers an interim conditions of practice order for a period of 18 months, in the same terms as any substantive order imposed, is necessary for the protection of the public and is otherwise in the public interest. This will cover the initial period of 28 days before the sanction comes into effect, and the time taken for the Court to consider an appeal in the event that one is lodged.'*

Decision and reasons on interim order

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 reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mr Migraso is sent the decision of this hearing in writing.

That concludes this determination.