Governing for Excellence in the Social Care Sector - The Role of Self-Governance in Ireland's Evolving Social Care Profession

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Abstract

Social care work in Ireland remains a poorly understood profession, despite its growing importance within the wider health and welfare sectors. Higher Educational programmes, especially practice-based aspects, in conjunction with the imminent professional registration of social care graduates, will help with identity formation and solidification of this role (McGregor 2011). However, this professional registration has yet to occur and, on its own, will not guarantee the delivery of a quality service to the user. Using less commonly used professional development concepts of self-governance, self-regulation, impression management and identity capital, this article will explore how social care professional identity may be nurtured, developed and supported within professional practice learning and social care worker environments and, in so doing, support a quality service delivery within the social care space.

Keywords: impression management; professionalism; self-governance; self-regulation

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Overview

In a changing and more regulated working world, the idea of professionalism is topical, whereby questions arise about what is a profession and what is professionalism (Evetts 2006). Freidson (1970b: xvii) provides some guidance by defining a profession as,

> An occupation which has assumed a dominant position in a division of labour so that it gains control over the determination of the substance of its own work. Unlike most occupations, it is autonomous and self-directing.

This may be in part determined by its legal status and the requirements of a recognised educational credential (Joyce *et al.* 2009, McSweeney 2011). There are a number of well-established and well-known professions, such as medicine, law and accountancy, which are synonymous with our understanding of what a profession is, i.e. someone who is qualified, recognisable and, while they work with others, is independent in the specific job role they undertake.

Professionalism and what it means is a more context-dependent and contextual concept. What is understood as professionalism in one discipline and agency may be different from another's understanding of what constitutes professionalism. This, coupled with a well-established, or even innate set of personal qualities and value constructions of what a person believes is professionalism, which is changeable depending on a number of factors and "given meaning by the various [embodied] actions undertaken by [an individual] to demonstrate 'mastery' of a professional idea" (Adamson and Johansson 2016: 2202), makes this a very complex thing indeed. What can be agreed is that:

> Professionalism…requires those working as professionals to be worthy of that trust, to put clients first, to maintain confidentiality and not use their knowledge for fraudulent purposes. In return for professionalism in client relations, some professionals are rewarded with authority, privileged rewards and high status (Evetts 2014: 32)

The idea of the professional and professionalism, when explored within Ireland's social care field, requires an examination of an emerging and evolving autonomous social care worker profession, soon to become formally regulated. This is the focus of this article. This review of the literature will explore the current professional status of the social care worker and, as such, it will examine the application of theoretical concepts and ideas that have been noted to support the development of a profession and professionals in the fields of business and health (Freidson 1970a, 1970b) and determine whether they have potential application and use in supporting social care workers during their transition to a regulated profession. These ideas include notions of governance, self-governance, self-regulation and impression management. These concepts have had been found to assist in clarifying and developing professional roles, instilling a value system and embedding a quality ethos within the person and the organisation (Stoker 1998, Schultze 2007). The article explores whether they can promote understanding within the social care context.

The social care worker

Social care work has its foundations in the institutional care context, where "modern social care practice was born out of 'serious deficiencies' in the running of children centres and the need for professionally trained staff" (Kennedy and Gallagher cited in Lalor and Share 2013: 13). Accordingly, the term social care worker and accredited social care worker training has been in existence since the 1980s. However, while it has been in existence, there remains a lack of understanding to this day of what *is* a social care worker (Richardson 1996, McSweeney 2011, Lalor and Share 2013). Questions are asked by students and by those working in the sector itself, as to where and how social care differs from social work (Lalor and Share 2009). Even

within the discipline, social care worker roles can also be quite different (Farelly and O'Doherty 2005). For example, social care workers traditionally worked, and continue to do so, with children and adolescents in residential care; but also people with learning or physical disabilities; the homeless; people with alcohol/drug dependency; families in the community; older people; recent immigrants to Ireland and others (Health and Social Care Professionals Council (CORU) 2010, 2013). This diversity has made it difficult to establish the individual and group identity of the social care worker professional, regarding who they are and what they do, within both the social care space and the wider community. This has been exacerbated, over time, by the absence of professional recognition or regulation within the sector until the introduction of the Health and Social Care Professionals Act, 2005 (Amendment 2012, available from http://www.irishstatutebook.ie/eli/2012/act/46/enacted/en/html).

This diversity also presents a challenge to ensuring/demonstrating the provision and delivery of a quality service to those who use them (Finnerty 2012). Aspects of this quality include and require "(positive) attitudes and behaviour of staff, fluid communication of changes in care, flexibility of the service to meet changing needs, responsiveness of care workers, and skills, knowledge and trustworthiness" (Malley and Fernández 2010: 561). Knowledge, skills and competences that could be, and are demonstrated, but without a specific context of where and by whom, means that it cannot be verified and owned by the worker and profession. Consequently, this lack of a clear understanding surrounding the social care worker role has made it difficult for the social care worker to see themselves, and be viewed by others even today, as a designated profession or professionals (Share and Lalor 2013, CORU 2017b).

The impact of ambiguity can be considered both from a service user and professional perspective. Specifically, if the service user does not appreciate the role of the professional or what they do, or if the external environment is unclear, ambiguity will exist, with associated role confusion and service delivery role confusion likely to occur. For example, does a social care worker dispense medication, engage in personal care delivery, or investigate cases of child protection, and, if not, what in fact do they do? The perceived attitudes and, on this occasion uncertainty, of others surrounding this role, as projected to the professional, can reinforce a person's (unclear) identity. Many established professions do work in varied work situations and role ambiguity is not an issue. The difference is that they appear to have core values, moral principles, self-awareness and understanding of who they are regardless of the setting, i.e., their role as a lawyer, nurse, doctor, etc. (Holden, *et al.* 2012). This common identity is produced and reproduced by means of shared educational backgrounds, professional training and vocational experiences, and by membership of professional associations (local, regional, national and international), resulting in role clarity and practice (Evetts 2014: 32). A thing yet to be established with any real sense of uniformity or agreement within social care.

Good quality social care service does, of course, occur, as is evident in the many Health Information and Quality Authority (HIQA[1]) reports, but, because of the above lack of clarity surrounding the role of social care and the role of social care worker, it is difficult to determine, demonstrate or assure the wider community of the collective delivery of quality social care to all service users, regardless of the setting (Braye and Preston-Shoot 1995).

This role ambiguity is and will continue to be perpetuated and reproduced over time, unless time is spent acknowledging its existence and acting to address it. For example, for the social care

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[1] HIQA is the independent authority responsible for driving quality, safety and accountability in residential services for children, older people and people with disabilities in Ireland. HIQA has statutory powers to inspect and to register services (HIQA 2015).

worker, a lack of their own role clarity will impact on their mentoring roles for students' learning on placement and new staff entering the social care professional space. This additional level of complexity was noted at the recent launch of the *Standards of Proficiency for Social Care Workers and Criteria for Education and Training* (May 2017), where role clarity and social care worker identity was discussed by the professional body, social care workers and academics. All acknowledging the difficulties and challenges with this both in practice, in teaching and learning and in students making the transition to professional social care workers. With discussion extending to the quandary: if the identity of those in practice identity is in a period of transition, how do they/can they effectively mentor others into the social care professional space?

It is expected that the aforementioned legislation will go a significant way to addressing some of the above issues, to clarify roles, support professional practice, support the legitimacy and status of the profession and professional and, ultimately, assure quality service delivery (Evetts 2014). This legislation provides for the establishment of a system of statutory regulations for twelve designated health and social care professions, a Health and Social Care Professionals Council with overall responsibility for the regulatory system, and a committee structure to deal with disciplinary and fitness to practice matters. These bodies are collectively known as CORU (originating from the Irish word *cóir*, meaning fair, just and proper[2]), and are tasked with the responsibility of protecting the public by regulating health and social care professionals in Ireland (CORU 2017a) through the following mechanisms:

- Setting the standards that health and social care professionals must meet
- Ensuring that the relevant educational bodies deliver qualifications that prepare professionals to provide safe and appropriate care
- Maintaining and publishing a register of health and social care professionals who meet the standards, e.g. through possession of a recognised accredited degree level educational qualification and ongoing professional development
- Ensuring that registered professionals keep their skills up-to-date by promoting continuing professional development
- Facilitating and leading Fitness to Practise hearings into the conduct and competence of a registrant (CORU 2017a)

The speed at which registration is occurring for the social care worker is perhaps not as would be liked (Farrelly and O'Doherty 2011). Some progress is noted with the recent establishment and appointment of members to the Social Care Workers Registration Board and the pending review of education programmes within the sector, which is expected to be completed by 2018 (CORU 2017b).

For the service user, the inherent advantage of an effective registration and regulation process is that it instils confidence that their health and social care professionals are properly regulated and qualified for the job (Banks 2004). For the social care profession, it will provide clarity as to what a social care professional is and guidance on the key knowledge, skills and competencies a social care worker must display and put in practice, and, in so doing, assist in the development of professional self-identity of the social care worker. Registration and regulation can also bring with it prestige, status and power to the professional (Evetts 2014).

However, formal registration alone will not make the social care environment and service delivery a success. Effort is required to embed the ethos of registration and an understanding of what a regulated profession is and can provide (standards, skills, knowledge, competency authority, and legitimacy) to the individual, the organisation, the service, and, ultimately, the service users themselves. Consequently, there is significant work required at the individual

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[2] http://www.coru.ie/en/faq [18 September 2017]

social care professional level to understand what it means to be considered a professional within today's social care space. To begin this work, it is necessary to examine the social care worker's professional identity.

Professional identity

Professional identity is defined as "one's professional self-concept based on attributes, beliefs, values, motives and experiences" (Slay and Smith 2010: 86), whereby one's identity allows one to note similarities in others and brings about a sense of collectiveness. Professional identity is viewed as an ongoing process that first encompasses the 'sense of self', created through social interactions with others, including other professionals and service users (Rodríguez *et al.* 2014). These interactions shape our identity and make us behave in a way that is considered acceptable by our peers and others. Within our daily work, professional identity provides a blueprint for how we behave in the workplace (Ibarra 1999). This presents difficulties to the social care worker since they do not, as yet, have a full sense and agreement of who they are (McSweeney 2011)

Therefore, the question is how can you develop this identity within an emerging profession such as social care? The answer may be found in the process of identity formation. In its generic sense, this formation is anchored in a sense of 'being part of'—a web of relationships, group solidarity, and communal culture (Dall'Alba 2009, Flum and Kaplan 2012). As these relationships and group solidarity do not yet exist, we have to find another way to begin this identity formation.

Fortunately, a professional identity is equally created and recreated through professional discourse. The language used within this discourse can serve to present a clear professional image to the world (Rodriguez *et al.* 2014). Those who construct viable professional images are perceived as being capable of meeting the technological and social demands of their jobs, conveying qualities that they want others to see in them (Roberts 2005: 687). Symbols and representations are an important part of this narrative, marking the way we share identities with some people and differentiate ourselves from others (Woodward 2004:7). This has potential within social care, since, as no real fixed image exists about what social care working is, a desired or ideal image could be constructed and developed based on professionals' knowledge, skills, abilities, experiences and values (Roberts 2005). This developed image, spread through discourse, could serve as a future, goal-oriented component of the self-concept (Baumeister 1989).

To assist in this process, we need to explore the active application of ideas such as governance and impression management to the role of the social care worker, both within practice and when practising. Governance can guide the professional on how to adopt the key characteristics and behaviour of a professional, and impression management can guide us on how to present this image to the world.

Both impression management and governance may help in the initial construction and evolution of this identity, which can later be transferred through socialisation between groups (Ashford and Taylor 1990) e.g. servicer users, students, society and new employees, then reaffirmed and supported when regulation of the profession occurs.

Governance

The notion of governance originates from the Latin *gubernare*, to govern, direct, or guide (dos Santos *et al.* 2013). Governance does not simply refer to the actions of the state or government, but has been more commonly used in recent times to refer to the wider arena of power (Kjær 2011). It is ultimately concerned with creating the conditions for ordered rules and collective action (Stoker 1998). Core to this notion of governance are the principles of legitimacy,

efficiency, democracy and accountability (Kjær 2011). The emerging interest and importance of governance within the public sector has been marked by the increased delivery of public services via civil society organisations, and the subsequent decrease in the direct role of the state in public service delivery. A key characteristic of this governance model is a focus on the inter-relationships and organisational culture (Addicott 2008), which drive direction and control within these organisations.

At the professional level, the concept of governance and its relationship with good practice within healthcare, a field closely related to social care, was first noted in the consultation document, *A First Class Service: Quality in the New NHS* (National Health Service Executive 1998: 1.13), where it outlined a systematic model of quality improvement that "marries clinical judgment with clear national standards", heretofore termed clinical governance. In March 1999, the document, *Clinical Governance: Quality in the NHS* (National Health Service Executive 1999: 116), set out in some detail this model for consolidating previous approaches to quality. The purpose of this clinical governance was to "safeguard high standards of care by creating an environment in which excellence in clinical care will flourish" (National Health Service Executive 1998: 116). This has led to the acknowledgement that the experts (delivering the care) require additional systems to ensure quality service delivery. While this concept may sound theoretical and aspirational, it is, in fact, practice-led, whereby the primary concern is the actions of every practitioner, and how well they meet the service standards set out in the model of achievement.

Consequently, the significant aspect of (clinical) governance is the reliance on making individual practitioners responsible for developing their skills for accessing evidence, ensuring that practice is, as far as possible, 'evidence-based', and being responsible for their own professional development and accountable for their implementation of quality standards (NHS Executive 1999, Brown and Crawford 2003).

Within the Irish context, clinical governance has also been adopted with the establishment of the Health Service Executive-led Health Information and Quality Authority (HIQA). HIQA, the independent body established to support a quality service provision within specific parts of Ireland's health and social care sectors, conclude that "Appropriate governance and management structures are required, which are part of the overall governance structure, including clinical governance, to support information governance within a service" (HIQA 2012: 9). This HIQA process, while not ignoring its difficulties, has proven to be somewhat successful in promoting quality, supporting the achievement of national standards of best service delivery (Jones 2015). Within social care, this quality framework is evidenced through standards of practice, which are intended "to protect vulnerable people of all ages who are receiving residential care services and to ensure that these people are receiving an appropriate standard and quality of service" (HIQA 2013: 15). Social care standards include National Standards for Residential Care Settings for Older People in Ireland; National Standards for Children's Services; and National Standards for Residential Services for Children and Adults with Disabilities 2013. The standards have been mandated by the Minister for Health, the Minister for Children and Youth Affairs, the Minister for Health, and the Minister for Children and Youth Affairs. All agencies within this remit must be registered and will be subject to inspection and monitoring against the relevant standards and the legal regulations published by the government (HIQA 2016).

Social care workers are employed extensively in residential care settings; however, as mentioned previously, they may also work within publically-funded community settings, a range of charitable and non-government organisations, and, increasingly, private non-residential care agencies. As a result, both HIQA and the Health Service Executive cannot ensure the quality of service delivery by social care workers in their totality, but merely provide standards of quality that professionals engage with for those services to which they are mandated.

In the absence of, or in tandem with, this macro level governance of diverse social care settings, the overall governance of social care needs to be influenced by governance principles with a view to developing this within individuals in each independent setting, through the ideas

of self-governance. This offers a framework/opportunity that is relevant and applicable to the significantly changing environment that is occurring within social care. CORU, too, has alluded to the notion and potential of self-governance, whereby they outline that "Each registrant must make sure that his/her knowledge, skills and performance are of a high quality, up to date, and relevant to the registrant's practice" (CORU Framework for a Common Code of Professional Conduct and Ethics 2010: 6). However, it is not merely the regulated governance within social care that should fuel this need for self-regulation, numerous arguments are advanced and generally accepted that self-regulation within professions is much more effective in supporting professional practice than external regulation (Cruess and Cruess 2005, Sidel 2005). This is something that will, therefore, be of value and benefit to service development and delivery overall.

The role of self-governance

Self-governance can be referred to as having control over oneself, to act in a way that is relevant to one's own profession, to know who you are and, therefore, behave in the way your profession expects (National Health Service Executive 1999). Tied up with this are the notions of self-regulation and autonomy, whereby the professional practices in a way that supports the ethos of a provision of quality care and services to clients (Ryan and Deci 2006). Here, professionals are expected to have both knowledge and understanding of the framework for professional practice, and must demonstrate this through their practice (Hinchliff, Norman, and Schober 2008: 9).

Within an evolving profession such as social care, and taking cognisance of its current sectoral flux, the key to quality service provision may be in supporting the development of self-regulation. Embedding the ethos of accountability and self-regulation in the mind-set of professionals during this period of transition towards a regulated profession can aid the long-term development of a quality service provision. It is this accountability within each professional that gives self-governance and self-regulation real potential (Department of Health 2009). Evetts (2014: 44) agrees, concluding that, in public sector professions, occupational professionalism is "increasingly achieved by means of normative values and self-regulated motivation."

Self-regulation and self-governance, therefore, most often coexist within notions of the role of a professional and professionalism itself. The professional enjoys the benefits of title, independence, self-governance, and (in the social care future) protection by state policy and professional bodies, while equally having significant responsibility and a commitment to behave as a professional at all times (Whitty 2000).

While the regulatory body sets the standards, it is individuals who ensure its success and become the advocate, the champion, of professional standards (Sullivan 1995). When social care becomes a designated and regulated profession, it will allow social care workers to become agents in this field and will formalise the idea of self-regulation. Without this ability to self-regulate and self-govern there is a risk of losing the privilege, and human and social capital that will exist within the new social care sector, once it is considered a professional occupation (Bourdieu 1986, Cruess and Cruess 2005, Sieger, Fritz and Them 2012). Rather than the imposition of this ideal, it is an opportune time for the social care professionals to develop themselves, to self-regulate, to self- govern, and embed it further where it already exists, not just when registration occurs, but before, during and after registration. What could be referred to as through a process of becoming a social care professional. Dall'Alba (2009: 34) explains "[l]earning to become a professional involves not only what we know and can do, but also who we are (becoming)". "Becoming a [social care] professional, then, involves transformation of the self through embodying the routines and traditions of [this] profession" (Dall'Alba 2009: 37).

If achieved, this will support the development of a core value of quality service delivery within the individual who is self-regulating and self-governing in their practice, leading to the acceptance within the professional group and the sector to a new normative set of values and

beliefs. This is acknowledged within other professions where (self) governance is considered key, and is cited within codes of conduct for professional groups. An example is the *Code of Conduct and Ethics for Registered Nurses and Registered Midwives* (Bord Altranais 2014) Principle 3: Quality of Practice-Standards of Conduct 3 (21), which states "[y]ou should actively participate in good clinical governance to ensure safe, quality care." This provides nursing professionals with a blueprint for acceptable practice.

Adding to this early image of the self-governing and self-regulating social care professional is the possibility of exploring the further and ongoing development and presentation of this identity through means of impression management.

Impression management within social care

Impression management refers to the process by which individuals try to create, maintain or modify information about themselves in order to appear as they wish others to perceive them (Bozeman and Kacmar 1997, Provis 2010). At its simplest, it is the effort by individuals to control the images they project in social interactions. It involves "presenting an identity that seems appropriate for the situation" (Larson and Tsitsos 2012: 312). The roots of this concept can be found in Goffman's notion of self-presentation, involving an actor and their audience (a social care worker and their service user), interacting in a particular context and jointly defining a particular situation, with the person selecting the behaviour that will generate the best impression in their audience (Rodriguez *et al.* 2014). Goffman noted that individuals will purposefully manage the impressions they convey while interacting with others (Goffman 1956, Nagy, Kacmar, and Harris 2011: 231). Building an impression facilitates and aligns with the theoretical position and the possibility of the construction of a professional identity. People engage in self-presentation and impression management as a support to themselves when taking on new and existing roles, such as that of social care professional. The manner in which they are perceived in these roles may cause (positive or negative) evolution and changes within their own identity framework (Ibarra 1999). Through these experiences, the person labels themselves and others, while the experiences and behaviours occur in the context of "social identities, meanings and definitions of the situation" (Tedeschi 1981: 5). However, it is not merely about a visual image presented to the world, but about the values, beliefs and practice of the person that inform the image that they wish to portray.

Successful impression management and confidence in the image presented to the individual, and then the group, and to the external world, may, in part, be dependent on the idea of identity capital (Côté 1984). This is understood as "the wherewithal individuals use when engaging in transactions as they attempt to negotiate the tricky passages created by the obstacles of late-modern society" (Côté 1996: 424). This capital can either be tangible or intangible. In this context, tangible refers to previous knowledge and qualifications which can function as passports into social and institutional spheres' social care work. These provide a rite of passage for graduates to the professional social practice space (Côté and Levine 2002), and are considered "important tools in impression management and in the micro-politics of identity negotiations" (Goldie 2012: e645). On a daily basis, such tangible resources present an image that can support the development of a clear (social care) identity, which is presented to the external world. Intangible capital derives from more personal characteristics and abilities, such as control, self-regulation, governance, critical thinking abilities, focus used for negotiation of different contexts and, on this occasion, establishing one's position in the social care space (Goldie 2012). Worker's intangible assets can balance against tangible ones that they may not be in possession of, or, on this occasion, may not be understood in the wider community, e.g. what is a social care degree. During professional working, identity exchanges can and do occur, which, if successful, involve mutual acceptance of the interaction, i.e. the professional worker interaction, with stakeholders of clients, service users and organisations. The acceptance of the stakeholder group of this impression/identity will allow the worker to increase their identity capital within that space (Goldie 2012). Therefore, it is not just about what you have, i.e. qualifications, it is what you do in practice as a social care professional that can make the

difference. The notion of 'becoming' fits within this, where new impressions of our professional ideal self that we want to portray provides a vehicle and understandable mechanism towards this becoming (Dall'Alba 2009), whilst not ignoring or undervaluing the history and traditions of practice we bring with it.

If you do not possess the legitimate identity capital that a situation requires, you must find a way to get it (Côté and Levine 2002). It would, therefore, stand to reason that the social care professional could, or would, have the potential to build this impression, building on existing impressions, particularly for intangible capital, where work could occur to support the development of personal characteristics that would support successful interactions with stakeholders to actively "strategize to maximize their life-course outcomes" (Côté 1996: 424). Fortunately, identity formation is a dynamic process and, as such, the professional is in a constant process of transformation through life. This provides the opportunity to support the development and nurturing of a social care professional identity amongst existing and future social care professionals.

Putting it into practice

While the above suggests the potential of using less common (to this field) concepts and ideas to assist in building professional identity and the ideal self within social care, they are of limited value unless developed and used in practice. The next step is therefore to consider their application within undergraduate programmes of study, and for those currently in practice, where might they fit and be implemented.

Current programmes of learning are required, and do deliver the theory of professional practice throughout a student's degree programme. In tandem with this, is the compulsory learning placements within all social care worker professional training programmes (Quality and Qualifications Ireland (QQI) 2014). The classroom allows for the students' understanding and controlled practice and practising of theoretical concepts. However, theoretical concepts and ideas such as the above must be delivered through effective and relevant pedagogy. On this occasion, this will require active learning strategies such as case studies, role play, reflection, critical reflection and serious play, in order for them to be successful in establishing and building a student's professional identity (Cooney *et al.* 2015). The immersion in compulsory placement learning will allow the student to present and extend knowledge, skills, competencies and professional learned self, acquired in the classroom, to the service and service user. Like any other professional programme of learning, theory and practice cannot exist as non-related parts, as the sense of becoming can only be achieved by the merging and integration of both parts. The role of academic teams is to require the student not just to think, but act and feel like a professional during this learning (Dall'Alba 2009, Cruess *et al.* 2014). It begins on the first day of their programme and is embedded throughout all learning, presented as a journey towards the goal of supporting students to graduate and transition to become the professional self. The challenge during a period of sectoral change, is that this evolving professional self-identity must be matched within the sector they are entering in order for it to be sustainable over time.

Consequently, the same image, values, beliefs, self-regulation, and capital need to be nurtured within the established workforce. Perhaps a more challenging thing where role ambiguity has existed for a prolonged time. Continuing professional development (CPD) can play a part in this self-identify formation and reaffirmation. This CPD opportunity would need to examine, with the social care worker in practice, the past, present and future social care identity, to support the professional in determining what social care professional they would like to become, and what impression they want themselves and their profession to give within a regulated framework. The pending registration opens the door to this opportunity, as CPD is now a requirement for repeated registration of the professional. This would allow those to build up their identity capital in tandem with, and during, the process of their transition to a regulated profession, whereby the "optimal identity adaptation is based on the wise use of one's tangible and intangible resources in the identity markets" (social care space) (Kroger 2007: 94). Currently, professionals are

beginning to explore options for CPD, and this could be one such option and opportunity. Motivation to learn based on role ambiguity must be acknowledged and managed for the professional in work. The motivation to undertake CPD is currently extrinsic and, as such, is not ideal. Therefore, co-created CPD by practitioner and academic, built around existing systems of values, into future hopes and aspiration of their profession and their professional self, within a system undergoing change, has potential to allow for intrinsic motivation and engagement with learning (Bovill, Cook-Sather, Felten, Millard, and Moore-Cherry 2016, Share, Cavaliero, and McTaggart 2016). It is an opportune time to adopt this approach and develop this new type of CPD, allowing the professional to be an active rather than passive agent within this change. The professional in the field will then be able to nurture and replicate this within students on placement and graduates new to practice.

Role of organisations' governance

This article argues that, within the context of a developing professional and professionalism, it is necessary for the professional to make efforts to self-regulate, self-govern and in doing so build a professional identity to support their successful transition to a regulated professional social care worker. This active engagement with these concepts will allow the individual to evolve and believe in themselves as social care professionals working towards a collective and community of professional social care workers. This does not take away from the role that formal regulation plays in this process, but provides an opportunity for the individual to be a confident, self-determining professional within the social care environment. However, to make it more attainable for the professional, this self-regulation should be supported by organisations within the social care sector. The principles of good governance, as outlined by Kjær (2004), of legitimacy, efficiency, democracy and accountability, with the inclusion by Argüden (2011) of transparency, will support professional self-regulation, but this should co-exist within a framework of good organisational governance. Equally, the continual practice of the ethos and values of good organisational governance will support the establishment in an organisation of a culture of/belief in self-regulation.

Recent initiatives around governance codes, changes in corporate and charity legislation, and increased accountability from the stakeholders within the wider sector, are evidence of the increasing emphasis on the role of governance to support quality at a sectoral, organisational, and individual level. The current development of CORU's *Code of Professional Conduct and Ethics* for social care workers reflects this trend (CORU 2010).

The guiding mantra of 'protection of the public from harm' versus 'excellence in care' can be placed on a continuum, wherein the combination of good organisational governance and self-regulating professionalism encourages the individual social care professional beyond their basic regulatory responsibility to 'protect from harm' to their ethical duty to provide 'excellence in care'. How can this be achieved? While a regulatory framework will prescribe standards and deliver a certain security within their professionalisation, it is identity capital, ideal identity development and good governance that will support professional autonomy, essential to the realisation of a professional identity for the social care worker. While the primary purpose of professional self-regulation is 'to protect' (CORU 2017a), support for the development of a culture of good governance will encourage the pursuit of 'excellence in care'. The challenge also, therefore, lies with CORU, as the regulatory body, and with the wider sector, to lay the foundations for the emerging social care profession, to let them self-govern, self-regulate and be the professional they aspire to be.

Conclusion

This article discusses the evolving identity of social care workers within their organisation and the wider social care sector in Ireland. It outlines the values of the pending registration on the establishment of this profession, but acknowledges that this alone will not achieve or confirm a

quality service delivery. Social care workers must be supported to work towards a belief and self-assurance in themselves as professionals and, in so doing, enhance their identity capital, their ability to self-regulate and develop a framework of good governance within the sector as a whole. Registration is a part of the process of building capacity of the social profession, not an end in itself. It is the individual social care worker who will achieve the requirements of CORU, and it is the social care profession collectively which will determine the quality of social care delivery (Stets and Burke 2000). To do so, social care workers require an opportunity and the support to develop and present an identity, individually and collectively, to the social care sector that offers assurance on the quality of their, and the sector's, service delivery.

CORU, as an organisation, also has a role. The lack of a specific mention of governance within the quality framework should be addressed with an emphasis on the role of good self-governance in contributing to quality care. This places governance on our professional agenda and emphasises the individual responsibility to engage in a culture of good governance. Attree (2005) agrees with this premise, concluding that health care professionals have a perceived lack of governance over their practice which requires investigation and attention if occupational dissatisfaction, stress, staff turnover and low morale, which impact on quality care, are to be reduced.

Educational institutions must recognise the necessity for strong professional identity formation and continue to build opportunities for the development of this within programmes of learning for future graduates. For those already working in the sector, opportunities must be provided to nurture and support the development of practitioner identity, autonomy and self-governance to meet individual professional needs, and to contribute to enhanced sectoral quality. CPD co-created learning has a role to play here and should be considered.

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