Ready or not? Statutory registration, regulation and continuing professional development for social care workers in Ireland

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Introduction

Social care work has evolved rapidly over the past forty years in Ireland (Lalor & Share, 2013). While its roots were in residential child care, social care workers now engage with a diverse range of service users across voluntary, community, statutory and private agencies (Howard & Lyons, 2014). As such, the context of social care practice has changed dramatically in Ireland. Yet the profession arguably faces its most significant watershed in terms of its professional development, with the introduction of statutory registration under the Health and Social Care Professionals Act, 2005 (as amended, 2012). This legislation established CORU, the first multi-professional health and social care regulator in Ireland. Social care workers, as one of fifteen professions subject to regulation by CORU, will be required to register in order to be legally entitled to practise using their professional title (Hanrahan, 2016). This paper will examine the process of registration for social care workers. An analysis of the current opportunities and challenges posed by statutory registration of the social care profession will be detailed. In particular, attention is given

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to the introduction of mandatory continuing professional development (CPD) and its implications for individual practitioners and employers. This paper will also examine CPD standards established by CORU and explore models of measuring compliance with professional CPD requirements.

Regulation of health and social care professions

Internationally, the regulation of health professions is gaining momentum through either self-governed professional structures or legislated state bodies. For example, in the UK, the Health and Care Professions Council (HCPC), established in 2001, is responsible for the regulation of sixteen professions. The Health Professions Council of South Africa, established in 1974, regulates twelve professions through professional boards. In Australia a Health Practitioner Regulation Agency supports individual professional boards to regulate health professions, and in Canada most health professions are self-regulated through provincial authorities called colleges or orders. Whether self-regulation or statutory, commonalities exist with regard to regulation across professions. These include establishing minimum educational standards for entry to the profession and setting standards for practice, including engagement in CPD.

In Ireland regulation of nurses and midwives, medical doctors and pharmacists is legislated under the Medical Practitioners Act, 2007, the Nurses Act, 1985, and the Pharmacy Act, 2007. Each of these professions is subject to regulation and must adhere to a professional code of practice and conduct. It is argued that the expanded regulation of health and social care professionals has occurred due to highly publicised cases of poor or dangerous practice (Halton et al., 2015). These have caused public outcry and led to demands for increased professional accountability and protection of the public (Dixon-Woods et al., 2011).

Social care, like other health sectors, has witnessed what Howard (2012) refers to as 'shadows of madness, sadness and badness' (p. 12). Highly publicised reports documenting failures of the Irish care system have revealed incidents of criminal neglect and the abuse of children and vulnerable adults by those charged with their care. Howard argues that the profession struggled to comprehend the revelations of 'broken trust and innocence betrayed' in the midst of public outcry, heightened fear of allegation and increasing regulation (p. 19). As such, registration of social care work is hardly surprising and has in fact long

been called for by the profession itself (Howard & Lyons, 2014). However, this will not be without challenge, as regulation of social care work poses significant complexity to a multi-professional regulator such as CORU.

CORU – Multi-professional health and social care regulator

The Health and Social Care Professionals Act, 2005 (as amended, 2012), introduced regulation for fifteen health and social care professions (see Table 1).

Table 1: Health and social care professions subject to regulation

Social care workers	Social workers
Psychologists	Radiographers/radiation therapists
Physiotherapists	Orthoptists
Speech and language therapists	Podiatrists
Dieticians	Clinical biochemists
Occupational therapists	Medical scientists
Optometrists	Dispensing opticians

Note: Radiographers and radiation therapists are separate professions regulated by one registration board.

The Health and Social Care Professionals Act, 2005, established CORU as a multi-professional regulator, whose primary aim is to protect the public. This is achieved by promoting high standards of professional conduct, professional education, training and competence amongst health and social care professionals. CORU (2013a) consists of a Health and Social Care Professionals Council, under which a registration board will be established for each of the professions named within the legislation. Each registration board will consist of public representatives, as well as members from professional practice, management and education. The constitution of the board favours a lay majority to ensure public interest, rather than the interests of the profession, is served (Dixon-Woods et al., 2011; Hanrahan, 2016).

Each registration board is tasked with:

- establishing and maintaining a register of members of its profession;
- approving and monitoring education and training programmes for entry to the profession;
- recognising qualifications gained outside the state;
- setting a code of professional conduct and ethics for registrants.

The Act provides legal protection of professional title, meaning that it will be an offence to use the title unless registered with the designated board. CORU (2013b) maintains that regulation will increase public confidence in health and social care services (Hanrahan, 2016). Yet McLoughlin (2007) argues that the publicity that often surrounds professional disciplinary procedures in the UK only serves to heighten public anxiety. CORU (2013b) also contends that regulation will protect the reputation of the profession by establishing disciplinary procedures to address poor or dangerous practice. Although concerns exist with regard to the media representation of fitness-to-practise cases and potential implications for professional practice, there is general agreement that disciplinary procedures are required for a small minority of professionals who do not, or cannot, practise safely (Dixon-Woods et al., 2011; Healy, 2016).

Currently, six professional registration boards have been appointed. Social workers and radiographers/radiation therapists have completed a transitional phase referred to as grand parenting. This is a two-year period for which specified clauses are outlined within legislation to provide those currently in practice with eligibility to apply for registration. Once this transitional period is completed, only those who complete an approved educational programme, or who are returning to practice, will be eligible to register with the designated board. At present, two further professions – occupational therapists and speech and language therapists – are currently undergoing this grand parenting process, with registration for physiotherapists anticipated to open soon. Although long awaited, registration and regulation of social care workers are moving forward with the establishment of the Social Care Work Registration Board.

Statutory registration of social care workers

The Social Care Work Registration Board was the sixth board appointed by the Minister for Health, in April 2015. While registration has not yet opened for social care workers, it is anticipated to take place in due course. The profession is faced with a multitude of challenges which require redress before registration opens or regulation is introduced. Once registration opens, a two-year transitional period will allow time for those currently practising as social care workers to apply for registration. There are three eligibility criteria for social care workers applying to the board. The social care worker must:

- hold a qualification listed in Schedule 3 of the Health and Social Care Professionals Act, 2005, identified by legislation as:
  - National Diploma in Childcare awarded by the Higher Education and Training Awards Council/Dublin Institute of Technology; or
  - Diploma in Social Care awarded by the Higher Education and Training Awards Council/Dublin Institute of Technology; or
  - National Diploma in Applied Social Care Studies awarded by the Higher Education and Training Awards Council/Dublin Institute of Technology; or
  - Diploma in Applied Social Studies/Social Care from the Dublin Institute of Technology; or
  - Open Training College National Diploma in Applied Social Studies (Disability);
- or hold an equivalent qualification determined by the registration board as relevant to the profession and not less than a Schedule 3 qualification;
- or prove competency to practise, by demonstrating required length of practice and meeting standards of proficiency for the profession.

It is estimated that approximately 8,000 practitioners will be eligible to register as 'social care workers' during the transitional phase, the largest profession subject to regulation by CORU (Lalor & Share, 2013). The eligibility criteria defined for the social care work profession during transition recognise the ambiguity which has existed in relation to educational qualifications and employment practices across the sector. Despite legislation in 2005 identifying minimum educational qualifications for registration, non-qualified workers or those with alternative qualifications continue to be employed as social care workers in some sectors (Hanrahan, 2016; Keogh & Byrne, 2015). The current criteria defined by legislation for eligibility to register will only be available during grand parenting. This will address many of the inconsistencies which currently exist with regard to minimum educational standards for the profession. However, regulation of social care work faces a more immediate challenge related to professional title.

Protection of professional title

Under the current legislation, only those practising using the professional title of 'social care worker' will be legally required to

register. There will be no legal onus to register for social care workers employed under a variant employment title, even if performing what are essentially social care worker duties. Further to this, questions have recently been raised by the regulator as to the eligibility of those currently employed in related social care roles to register, despite having a Schedule 3 qualification. It has been suggested that those practitioners may be required to fulfil criteria for return to practice before being approved for registration. The challenge of professional title is evident from recent job advertisements requiring a social care work qualification, but being advertised under a multitude of titles, including project worker, outreach worker, aftercare worker, family support worker, support worker, care worker, night shift supervisor, locum worker and community child care worker, to name but a few. Exemplifying the lack of clarity with regard to professional title, the *Child and Adolescent Mental Health Services Standard Operating Procedure* (Health Service Executive, 2015) refers to 'child care workers', rather than the legally protected title of 'social care worker'.

Furthermore, the Irish Association of Social Care Workers recently reiterated concerns to the registration board regarding social care work employment titles being revised and/or being open to revision. This could result in non-registered workers continuing to be engaged in practice with vulnerable children and adults under different titles, performing what are essentially social care worker duties. As only those who are registered with CORU are subject to adherence to a professional code of conduct and ethics, this poses significant risk. If clarity of professional title is not achieved, and enforced by statutory and funding bodies, regulation of the social care work profession may be diluted. This issue alone poses significant challenge to regulators whose primary role is protection of the public (Keogh & Byrne, 2015). As such, CORU can only enforce minimum thresholds for safe and competent practice for those registered as social care workers (Hanrahan, 2016).

Yet addressing this challenge is not the remit of CORU alone. Despite the complexities, statutory agencies such as the Health Service Executive[1] and Tusla, the Child and Family Agency,[2] could address any continuing ambiguities within their own agency with regard to the

[1] The Health Service Executive is responsible for the provision of healthcare, providing health and personal social services for everyone living in Ireland with public funds.
[2] Tusla was established on 1 January 2014 and is the dedicated state agency responsible for improving well-being and outcomes for children. It is responsible for the protection and care of vulnerable children and families.

professional titles for social care workers. For example, each agency provides funding to a range of community, voluntary and private services which employ social care workers under various titles. By including a provision with regard to professional title and registration for social care workers within service-level agreements, steps could be taken to ensure clarity of professional title and assure effective regulation across the profession. It is also within the remit of the Health Information and Quality Authority, which inspects organisational recruitment practices such as registration of nursing staff, to reinforce social care worker registration with CORU and to identify non-compliance with legislation.

Code of professional conduct and fitness to practise

The registration board is tasked with setting a code of professional conduct and ethics, to which social care registrants will be required to adhere (CORU, 2013c). Once drafted, CORU will invite stakeholders to consult on this code to ensure it is robust and effective in supporting social care workers in their practice. Examples of possible standards can be drawn from the *Code of Professional Conduct and Ethics for Social Workers* (CORU, 2011), as social work is the profession most closely allied to social care work. These include ensuring respect for and dignity of service users, undertaking duties professionally and ethically, as well as maintaining high standards of personal conduct. Registrants will also be required to act within the limits of professional knowledge, skills and experience, as well as keep professional knowledge and skills up to date. Failure to adhere to this code of conduct could result in disciplinary procedures to determine fitness to practise.

Fitness to practise is concerned with complaints related to a registrant's professional conduct and competence, or those related to the health of the registrant which may impede their capacity to practise safely (CORU, 2014). Fitness-to-practise legislation was enacted on 31 December 2014, and complaints may be made by any individual, employer or organisation. CORU will receive a complaint against any professional who is currently registered. While social care workers are not yet registered, a complaint can be received in the future if it refers to any date on or after 1 January 2015. Fitness to practise aims to protect not only the public but also the reputation of the profession itself. It establishes legal mechanisms by which professional accountability and poor or negligent practice can be

addressed. It is anticipated that this will only apply to a small minority of registrants. For example, in the UK 0.56% of health and care professionals registered with HCPC between 2011 and 2012 were subject to a fitness-to-practise hearing (Health and Care Professions Council, 2013).

If one extrapolates from the situation in Scotland, social care work is likely to incur higher rates of complaints than many other health professions. In Scotland residential child care workers receive 20 per cent of all complaints, although the profession only constitutes 5 per cent of the social services workforce, inclusive of social workers, child care workers and care workers caring for adults (Smith, 2016). This is due to the complex and often challenging nature of social care work (McLaughlin et al., 2015; Reamer, 2006). Social care workers are often confronted with the intensity of service user emotions, which create ambiguous and subjective spaces around intimacy and boundaries, something not encountered to the same degree by other health professions (Smith, 2016). Smith (2002, p. 9) cautions against what may appear to be 'an endless cycle of complaint and investigation'. If regulation is perceived as being overly punitive, it may serve to increase managerialist principles and create a risk-adverse professional culture (Halton et al., 2015). Trevithick (2014) cautions that managerialism fails to acknowledge the importance of relationship-based practice, can create situations where professional and organisational defences dominate, and can lead to compliance rather than independent thinking and decision-making (Munro, 2010).

Although research is limited, some findings suggest that media portrayal of fitness-to-practise cases can lead to an increase in risk avoidance, preoccupation with compliance and perceptions of a blame culture, and to a reduction in professional creativity (McGivern & Fischer, 2012; Meyelal, 2012). Social care workers must strive to achieve a balance in the provision of care and compliance with professional standards of regulation. It is important that care and relationships are not lost to a cycle (or fear) of complaint or investigation (Howard & Lyons, 2014). The regulator's role is central to ensuring that this balance is achieved. However, for a multi-professional health regulator, this requires a reinterpretation of what it means to be 'professional' within the context of care. Smith (as cited in Howard, 2012, p. 46) argues that:

> Caring requires a rethink of what it means to be professional in the human services. In current discourse, to be professional is to be objective, rational and unengaged at any emotional level…

being professional is about getting the job done, competently and ethically. So any proper consideration of what it is to be professional needs to start with what the job is. If the job is to make intimate human connections with those we work with to help them develop, conceptions of the professional ought to support this.

CORU contends that it recognises the challenges which exist in balancing regulation and instituting disciplinary procedures for those practising within the complexity of human services (Hanrahan, 2016). They maintain that, for this purpose, complaints are initially reviewed by a preliminary proceedings committee and a registrant is informed of the complaint. The role of this committee is to determine if the complaint is justified and, if so, whether it is a breach of the registrant's code of professional conduct and ethics. If a complaint is deemed to be malicious or unfounded, it will not proceed further. However, if evidence supports the complaint, a fitness-to-practise hearing will be convened. The registrant is invited to attend this hearing to present evidence. The committee will consider the evidence and make a recommendation to the Health and Social Care Professions Council. This may be that the complaint was unfounded but, if not, the council may admonish or apply a sanction to the registrant. The sanction may be to apply conditions of practice, or it may result in suspension from the register or cancellation of registration (i.e. struck off the register) (CORU, 2014).

In the case of a sanction being imposed, a registrant has a right of appeal to the High Court (CORU, 2014). McLaughlin (2010), in a review of appeals against fitness-to-practise decisions in England, argued that a power imbalance existed, with registrants often appearing without the aid of legal representation. It was found that registrants were more likely to be successful when they had legal representation, as compared with those self-representing. Moreover, McLaughlin (2010) questioned the potential for moral judgement when personal behaviour, outside of the work context and not impinging on professional practice, is within the remit of investigation. This will be a paradigm shift for the social care profession, involving both the legal and judicial system in professional practice and individual accountability. Social care workers must now consider issues such as professional indemnity insurance and legal protection for individual practice, likely to be a requirement for future practice as a result of professional regulation.

This in itself has implications for a profession where entry has typically been through relief or voluntary work, often marked by low- or non-paid experience. Further to this, newly qualified social care workers often incur costs for completion of mandatory training, not provided for in undergraduate courses. Such impediments, related to financial resources and legal accountability, may have implications for attracting, recruiting and retaining new graduates to the profession. Social care work is an already challenging profession, which can exert significant emotional and physical demands in difficult work environments, where, at times, traumatised and challenging service users are engaged (Lalor & Share, 2013). Over the last two decades the profession has witnessed increased levels of workplace violence and reduced pay scales for new entrants, as well as a lack of recognition of professional status, a lack of regular professional supervision and an absence of career-progression pathways (Colton & Roberts, 2007; Keogh, 2007; Williams & Lalor, 2001). Given the complexity and challenges of the work itself, alongside the cost implications for registration, the profession faces significant challenge in retaining experienced workers in some sectors.

Registration and continuing professional development

Linked to accountability and fitness to practise, a core feature of regulation is the introduction of mandatory CPD. This will be a prerequisite for maintenance of registration and demonstration of fitness to practise. Regulation requires that registrants ensure that their 'skills and knowledge are up to date, of a high quality and relevant to their practice' (CORU, 2013c, p. 9). The purpose of setting standards for CPD is to link registration with professional development and competence to practise. This aims to protect the public by ensuring high standards of practice (Munro, 2008). An increased emphasis on CPD among health professions is argued to be due to:

- extended professional careers;
- accelerated dissemination of knowledge, technology and research;
- changed societal expectation;
- increasingly complex, multidisciplinary work environments;
- linking learning to performance. (Filipe et al., 2014)

CPD must be perceived as a 'systematic process that is both credible and transparent' to the public (Filipe et al., 2014, p. 136). Hence, the

Health and Social Care Professionals Act, 2005, established CPD as a statutory requirement and empowered CORU to monitor compliance by health and social care registrants. Mandatory professional development may have been inevitable if health and social care professions were to be credited with professional status (Ross et al., 2013). However, measuring compliance with CPD standards continues to prove challenging (Fenwick, 2009). In New Zealand, for instance, the Social Work Registration Board was required to revise CPD standards in 2010 when it became evident, after a random audit, that social workers were not planning CPD in a purposeful way, had demonstrated limited evidence of reflection and had struggled to meet CPD requirements (Beddoe & Duke, 2013). Similarly, O'Sullivan (2003) found that physiotherapists in the UK were not maintaining a CPD portfolio due to a lack of time and skills, habit and a lack of value attached to the benefits of engaging in the process. Further to this, difficulty articulating and demonstrating CPD through a written portfolio was identified as a significant challenge for many.

Understanding CPD models and measuring compliance

Traditionally, professional development has been widely linked to engagement in continuing professional education (CPE) (Halton et al., 2015; O'Sullivan, 2003). Formal CPD activities are mandated for many health professions, and are often linked to regulation and continued competence to practise (Boud & Hager, 2012). CPE has been found to enhance individual knowledge and skills, but it is less clear how effective it has been on changing practice, improving service delivery or enhancing outcomes for service users (Austin et al., 2003; Chipchase et al., 2012). The measurement of compliance with CPD standards became focused on the input or time spent on formal learning, rather than the outcome for practice and service delivery. Yet input-based CPD models are criticised for failing to account for *actual* learning (French & Dowds, 2008). Time spent on an activity neither guarantees that learning has taken place nor that it will be integrated into practice.

Boud & Hager (2012) contend that input-based models may foster compliance with regulation by attaining required hours or credits but often distract from the nature of professional development itself. CPD-input models often presume that individualised acquisition of knowledge or skills through specialised or mandated activities is most worthwhile (Fenwick, 2009). These assumptions fail to account for

practice and 'knowing', which emerge due to the interaction of professionals and systems of practice. Professional development cannot be understood simply as a process of updating and absorbing information (Boud & Hager, 2012). Rather it is an organic, unfolding process which should be viewed as an 'integral part of professional activity within the work context' (Munro, 2008, p. 954). CPD is argued to provide a broader understanding of how professional development occurs within the work environment (Filipe et al., 2014).

Definitions of CPD vary, yet most share commonalities such as recognising that it is an ongoing process, is undertaken throughout a professional career, and incorporates both formal and informal learning (Halton et al., 2015). CORU defines CPD as:

> The means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional life. (CORU, 2013d, p. 11)

Despite this, health and social care professionals continue to indicate a preference for formal CPE (Attewell et al., 2005). This is perhaps understandable given the challenges in representing informal learning to others (Chipchase et al., 2012). Professionals often lack clarity as to what learning activities constitute CPD or how to represent 'knowing' which evolves over time within practice (Bell et al., 2001; Brady, 2014). The Irish Association of Social Care Workers undertook a survey of practitioners' CPD needs in 2014, as part of the process of developing a strategic plan to prepare for statutory registration requirements. This study found that social care workers were engaging in a broad range of both formal and informal learning activities. Yet 80 per cent (442 respondents; n=552) identified only training as their most recent CPD activity (Irish Association of Social Care Workers, 2014). This finding suggests there may be a lack of value or recognition given to informal learning, or possibly challenges in evidencing how this learning occurs to others.

CORU CPD requirements for CPD portfolio

CORU (2013d) has adopted a blended, or hybrid, approach to measure compliance with CPD standards. While maintaining an input measurement (i.e. CPD credits), the use of a CPD portfolio also measures output or outcomes of learning. Social care workers, once

registered, will be legally required to develop and maintain a portfolio of learning which includes a:

- description of professional role and practice setting;
- personal learning plan;
- CPD log or record of learning activities;
- demonstration of engagement in learning (for example, record of supervision, certificate of training attendance or reflective practice journal);
- minimum of eight reflective practice worksheets.

CPD standards will require social care workers to attain sixty CPD credits in each two-year CPD cycle. Registrants must engage in a self-directed review of learning needs at the beginning of each cycle. This review of learning needs informs the development of a personal learning plan, which sets out the skills and knowledge the registrant intends to develop over the course of each CPD cycle. Engagement in learning must be recorded in the portfolio, as well as evidence to demonstrate that each activity has taken place. Further to this, registrants must complete a minimum of eight reflective practice worksheets on different learning activities exploring the impact this learning has on their practice. At the end of each CPD cycle, a percentage of registrants will be selected and requested to submit their CPD portfolio for review. The CPD portfolio is one tool utilised by output models to measure compliance with standards. It provides a written record of the self-directed analysis of learning needs, reflection on learning activities and demonstration of the impact learning has had on practice (Halton et al., 2015). The use of a CPD portfolio is argued to be a more authentic measure of professional development that occurs within the context of practice (O'Sullivan, 2003).

Yet Boud & Hager (2012, p. 28) caution that the learning portfolio may serve to 'promote skills for self-portrayal', rather than actual learning or development. Self-assignment of CPD credits within the CPD portfolio as a measurement of compliance is one such area open to interpretation. CORU (2013d) identifies that one CPD credit equals approximately one hour of *new* learning. This continues a reliance on measuring professional development as time spent on an activity (i.e. input). Moreover, it is also dependent on the candour of a registrant when determining assignment of CPD credits. Self-directed planning and portfolio assembly also rely on personal and professional abilities such as self-awareness, self-reflection and critical

thinking, as well as confidence in professional competence. These skills require not simply time and experience to develop but also an organisational culture or systems of practice which value and nurture reflection. Concerns remain that over-formalising professional development may reduce personal commitment and investment in CPD (Boud & Hager, 2012).

While acknowledging these challenges, the CPD portfolio offers a more effective tool to demonstrate professional development than traditional models. CORU (2013d) will undertake an audit of registrants' CPD portfolios at the end of each CPD cycle, every two years, in order to measure compliance with professional standards. Each CPD portfolio is reviewed by trained assessors. If the portfolio is deemed non-compliant, the registration board may allow a registrant more time to become compliant. However, failure to submit a portfolio or continued failure to reach standards will result in a fitness-to-practise hearing.

Social care work and CPD

For social care workers, CPD is argued to be at its conception stage. While CPD requirements have existed for other health professions, there has not previously been a requirement for social care workers to engage in ongoing professional learning (Keogh, 2007). As a result, professional development has tended to be ad hoc, unstructured and often unplanned (Irish Association of Social Care Workers, 2014). Yet social care workers are well placed to engage in CPD due to the nature of their work, often within the context of multidisciplinary teams (Keogh & Byrne, 2015). For instance, a survey of social care workers highlighted significant engagement across a broad range of professional learning activities, undertaken in a work context or for personal interest. However, only 11 per cent (61 respondents; n=552) had a professional development plan in place, suggesting a lack of structure or planning for engagement in CPD (Irish Association of Social Care Workers, 2014).

In response to the findings of this study, Social Care Ireland (SCI), the umbrella body for the Irish Association of Social Care Workers, the Irish Association for Social Care Managers and the Irish Association of Social Care Educators, launched a *Continuing Professional Development Policy and Portfolio* for members in 2015. This aims to introduce a structured approach to CPD to prepare social care workers for registration requirements. As part of this process, a one-

year CPD cycle was launched, and an audit of members' portfolios was undertaken in early 2016. This aims to be a supportive process offering guidance and advice to social care workers on how to represent their professional development through the assembly of a learning portfolio. SCI contends that 'the CPD process requires a commitment by social care workers to career long learning as a means of keeping knowledge and skills updated to the highest possible standard to ensure they work safely, legally and in the best interests of service users' (Social Care Ireland, 2015, p. 7). The following standards were established by SCI for social care workers:

- Members must maintain a continuous, accurate and current record of their CPD activities using SCI portfolio and/or other CPD recording templates.
- Members must evidence how learning activities have met their priority learning needs and be able to demonstrate how engagement in CPD has enhanced or improved their standard of work.
- Members must demonstrate application of learning in their work practice and be able to reflect on how this learning has enhanced service delivery for service users.
- Members must engage in and reflect on a range of CPD activities relevant to current and evolving scopes of practice.
- Members must submit written evidence of CPD engagement upon request from SCI.

SCI contends that meaningful engagement in CPD must be a shared responsibility between the individual practitioner and their organisation. This can be achieved by supporting social care workers to review their learning needs, in line with organisation or service requirements. Employers can also support workers to develop a professional development plan, agreeing priority learning which can be supported by the organisation, or undertaken by the individual themselves. An agreement can also be reached regarding methods of recording and demonstrating engagement in learning activities within the workplace. Line managers are also instrumental in creating opportunities to reflect on the integration of learning into practice, as well as seeking creative opportunities to share learning in the day-to-day work environment. Overall, employers have a responsibility to support a culture which values and supports workers' engagement in CPD (Social Care Ireland, 2015, p. 24). Yet this is not without challenge to organisations themselves. Lack of resources to offer

protected time or employment incentives, as well as service demands and individual workers' motivation to engage in CPD, can impede its integration into organisational policy and culture (Moriarty & Manthorpe, 2014; Munro, 2008; O'Sullivan, 2003).

Implications of mandatory CPD

For social care workers, professional judgement often involves making decisions about complex and often challenging situations and human relationships. These decisions are often taken when faced with competing agendas of risk, safety and need, which require a depth of self-awareness and capacity for reflection. It is essential that opportunities to systematically explore practice are available to evaluate, review and further develop skills and capacities (Halton et al., 2015). Thus, professional development is not simply adherence to regulatory standards, but rather a reflective process drawing on individual capacities and organisational supports, and embedded within professional practice. Halton et al. (2015, p. 145) argue that a CPD portfolio can provide 'a tool that supports reflective engagement which helps to make explicit the knowledge, values and assumptions that are implicit to practice'. Yet challenges exist in creating an awareness of what constitutes CPD and developing the skills required to articulate and demonstrate professional development through a portfolio (Beddoe & Duke, 2013; O'Sullivan, 2003). The lack of prior standards for CPD, as well as the estimated numbers of practising social care workers who will be required to integrate new skills into professional practice, proves a considerable task for the profession in preparation for statutory registration.

While regulatory focus is on individual responsibility to engage in CPD, the individualisation of learning may create tensions between individual and organisational needs (Munro, 2008). Exemplifying this incongruence, a study of social care workers' CPD needs found that 35 per cent (193 respondents; n= 552) felt that organisational supports, such as in-service training, had little or no impact on their practice (Irish Association of Social Care Workers, 2014). Employers play a pivotal role in encouraging and facilitating professional development. However, if overly prescriptive, this support risks being limited to organisational needs, which may supersede an individual practitioner's CPD requirements and limit professional development. Tensions may also arise if professional development leads to individual questioning of organisational practices, which is not always welcomed.

Organisational approaches may also fail to recognise the broader benefits of supporting improvement or enhancement in professional practice for the profession itself (Munro, 2008).

A multitude of individual and organisational factors can serve to motivate or inhibit engagement in CPD, as well as the integration of learning into practice. Individual factors such as time, cost, personal circumstance and balancing work commitments can impact engagement in CPD (Brady, 2014; Halton et al., 2015). Further to this, management support and employment incentives, as well as service demands and resources, can either motivate or inhibit CPD. Munro (2008, p. 959) argues that an over-reliance on 'personal motivation, goodwill and personal financial circumstances' has undermined the value and worth of CPD within organisations. Also, a lack of consistency in career-advancement pathways creates uncertainty regarding the personal benefits in pursuing learning, where professional benefit is unclear (Halton et al., 2015; Munro, 2008). This issue is particularly pertinent for the social care profession, where career-progression pathways are limited or even blocked in some areas. Despite potential barriers, a study of social care workers' CPD needs found that 98 per cent (541 respondents; n=552) reported engaging in CPD activities in their workplace, while 79 per cent engaged in CPD activities in their personal time (Irish Association of Social Care Workers, 2014). This indicates a high level of personal commitment and motivation to engage in ongoing professional development.

Conclusion

Long awaited, statutory registration is in the process of being established for the social care work profession. This process is likely to be a challenging and tumultuous period for social care work. Issues related to professional title, eligibility to register, educational qualifications and financial costs have already led to ambiguity and misunderstanding as to what regulation entails. For many, regulation is closely associated with recognition as a profession. Yet regulation alone does not constitute professional status. This must be driven from within the profession itself, by developing a shared professional identity which promotes high standards of practice and recognition of the quality and value of social care work. Moreover, social care workers must have a clear understanding of the implications of, and the responsibilities ensuing from, professional regulation. While the

most immediate issue remains clarity with regard to professional title, the extent of other challenges cannot be minimised.

Yet regulation provides opportunities for the profession, including the establishment of minimum educational standards, protection of professional title and establishment of CPD standards. Although regulatory emphasis lies with an individual registrant to engage in CPD, employers also play a pivotal role in providing structures and supports which promote engagement in ongoing professional development. As such, CPD must be viewed as a joint responsibility, which may at times require negotiation and compromise, if both the individual and organisational needs are to be achieved. Ultimately, CPD should be of benefit to service users by enhancing service provision and individual professional practice. This requires an understanding of what constitutes CPD and the development of skills to articulate and demonstrate professional development through a CPD portfolio. Responsibility must lie with the profession to prepare for statutory registration requirements. Whether the profession is ready or not, statutory registration and regulation will take place. This will be a significant watershed in relation to the development of the profession, and one which is likely to have profound and lasting impact on social care work in Ireland.

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