



Just deserts: Do students deserve a safe learning environment?

Nursing Ethics
2026, Vol. 0(0) 1–11
© The Author(s) 2026



Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/09697330261487676
journals.sagepub.com/home/nej



Mark Philip Wareing¹  and Vasiliki Parlama¹

Abstract

This conceptual paper critically analyses the notion of safe learning environments in the context of the introduction of a safe learning environment charter within the National Health Service in England. The experience of nursing students within complex ecologies of practice learning is considered including the triggers and drivers for the charter including patient safety incidents, calls for positive learning cultures and the lived experiences of learners and trainees. The utility of clinical learning environments is explored through distributive justice to question the extent to which a safe learning environment can be regarded as a just desert. The authors conclude that professional identity formation is dependent on experiences that may be deemed unsafe and that the translation of a policy ideal into some clinical settings makes the elements of the charter difficult to standardise or implement, particularly when learners are regarded as having a shared responsibility for the charter.

Keywords

learning environment, safety, nursing student, desert, justice

What is original about this work?

This is the first philosophical consideration of safe clinical learning environments for nurses with reference to justice and rights-based theoretical perspectives. The paper critically analyses a ten-point charter that has been adopted with a particular focus on health professions students, within a wide range of clinical, therapeutic and healthcare setting. The article elucidates a range of key elements within clinical environments to question notions of safety, safe learning and to highlight the complexity of practice settings.

What impact is the work likely to have on care practice, leadership, research and/or education?

The paper will be of particular relevance to nurses with responsibility for the supervision, support and assessment of nursing students and educational leaders and managers with responsibility for the quality of

¹Department of Health Sciences, College of Health, Medicine & Life Sciences, Brunel University of London, London, UK

Corresponding author:

Mark Philip Wareing, Department of Health Sciences, College of Health, Medicine & Life Sciences, Brunel University of London, Room 301a, Mary Seacole Building, Kingston Lane, Uxbridge, London, UB8 3PH, UK.
Email: mark.wareing@brunel.ac.uk

learning environments. Educationalists and researchers with an interest in safe learning environments, inclusivity and reasonable adjustments will find the paper of particular value as the article suggests current gaps and priorities within published research.

Introduction

The call for safe clinical learning environments (CLEs) has become increasingly prominent across higher and professional education, particularly within practice-based disciplines where students learn within volatile, uncertain and complex settings. Policy documents, professional standards and institutional guidance assert safety as a foundational requirement for learning, wellbeing and professional formation.¹

Despite its widespread use, the concept of safety in learning remains undertheorised. What constitutes a safe learning environment, and on what moral grounds is safety claimed or withheld?

Nursing students in practice-based settings continue to report incivility, marginalisation and moral distress.² This persists despite commitments to safety within policy frameworks and regulatory guidance, raising questions about whether safety functions as an unconditional educational entitlement or as a conditional good.

This paper adopts a conceptual approach to examine the extent to which students may be said to deserve a safe learning environment and how such an environment ought to be understood. The notion of safety in clinical learning will be critically analysed through the lens of desert-based theories of justice to interrogate the underlying moral assumptions embedded within contemporary policies and guidelines.

The principle of desert-based justice is used to explore whether nursing students deserve a safe learning environment in which to complete the practice element of their pre-registration programmes. The authors consider the utility of a safe CLE, how distributive justice might inform what constitutes merit in practice learning and assessment and how safety reflects or obscures broader questions about justice, fairness and entitlement.

Background

Much of the educational literature frames safety instrumentally, positioning the learning environment as a condition that facilitates participation, reflection, and effective learning.^{1,3,4} This conceptual framing risks treating safety as contingent on organisational demands, or to be earned through appropriate behaviour, resilience or acceptable performance. Such assumptions sit uneasily with accounts of distributive justice, which foreground questions of fairness, and entitlement within modern society.⁵

Desert-based theories of justice are particularly pertinent within professional education contexts, where notions of merit, resilience, suitability and performance frequently shape a sense of belonging, attainment and student progression. This paper does not argue that safety in learning is contingent upon student behaviour, compliance or academic performance. Nor does it suggest that unsafe environments are pedagogically justified as mechanisms for testing suitability, resilience or professional commitment. The authors regard a safe clinical learning environment as a practice education imperative where there is clear evidence of compliance with legislation, organisational and professional standards, and where practice learning is valued by the host organisation as a driver for the enhancement of quality and clinical outcomes for the benefit of all. Rather, desert-based justice is introduced as a competing moral framework to interrogate why practice-based learning environments appear to operate as though safety must be earned, negotiated or endured. In this sense, the just-desert framework is used diagnostically rather than prescriptively, exposing the moral logic that tacitly underpins contemporary learning cultures. In doing so, this paper argues that while safety is rhetorically framed as foundational within contemporary policies and

professional standards, it frequently operates as a conditional good within practice education with important implications for how responsibility, vulnerability and institutional obligation is understood.

Clinical learning environments (CLEs)

The emphasis on a safe CLE invites reflection on the quality of educational, clinical and therapeutic settings in which learning occurs. In professional education, students are increasingly positioned within a complex ecology of practice learning where thinking, being and doing are linked to an environment described as a value-laden milieu of hope, ambition, challenge and disruption.⁶ Ecologies of learning are characterised when learning and the environment are indivisible within ecosystems that are natural and organic, enabling learning to occur in the flow of work. Tupper and Ellis⁷ suggest that learning in the flow of work requires a learner to develop a proactive mind and skillset that leads to consistent action through learning that is intentional and embedded in the rhythm and ritual of work.

Learners undertaking practice-based nursing education may experience moral distress, psychological harm and incivility whilst lacking the authority or security afforded to qualified healthcare professionals.⁸ The normalisation of such conditions raises ethical questions about whether exposure to risk is framed as an unavoidable feature of professional formation rather than a failure of educational responsibility. Milligan et al.'s⁹ systematic literature review into students raising concerns in clinical practice suggested that learners are reluctant to escalate a concern due to a fear that it will have an impact on the outcome of practice assessments. This leads to a critical question – can an environment be described as educational if students trade safety for success whilst on placements?

It is beyond the scope of this paper to examine all elements of safe learning, although issues of equality, diversity and inclusivity dominate discourses of safety within educational environments and research into the lived experience of nursing and midwifery students' practice education. Anderson¹⁰ identified that homophobic expression, physical and verbal harassment and cyberbullying are among the most common forms of anti-gay discrimination experienced by queer students within school environments, illustrating how access to safe learning environments is not uniformly afforded but mediated by social norms, power relations and inclusion. A consideration of early educational experience is relevant to the needs of nursing students as learner and ethnic identity is formed at school^{11–13} and shapes how adults engage in learning. Hagerty et al.'s¹⁴ theory of human relatedness suggested that human relatedness was a functional behavioural system rooted in early attachment patterns that shaped an individual's level of involvement with persons and groups and was concurrent with their level of comfort or discomfort. Connectedness and lack of involvement was seen as a resource for self-conservation to aid creativity, rest and concentration, when individuals experienced enmeshment with others, objects, groups and environments that became coupled with discomfort and anxiety. Competent relatedness was said to emerge from a sense of belongingness, reciprocity, mutuality and synchrony, when a person experienced congruence with their internal rhythms of interaction. The theory of human relatedness and strategies for self-conservation continues to speak to the experience of nursing and midwifery students who may utilise a timely withdrawal from a busy clinical environment to a quieter location to complete documentation, as a reasonable adjustment that lessens the impact of a neurodivergent condition. Hardie et al.³ describe a productive clinical learning environment as being dependent on positive interpersonal relations characterised by psychological safety that allows individuals to be their authentic selves, leading to an increase in learning that embraces uncertainty, rather than a reluctance to do or say something for fear of appearing incompetent. Such an environment requires learners to be supported by supervisors who use inclusive interpersonal and communication skills.

Kempen et al.'s⁴ study into millennial students (born 1981–2000) considered the notion of safe learning environments in relation to experiential learning theory, drawing on the work of David Kolb, in which learning is understood as a cyclical process involving concrete experience, reflection, conceptualisation and

active application.¹⁵ Within this framework, learners' awareness of their cognitive processes supports the development of self-directed learning. The study demonstrated that students feel safe when they encounter familiar teaching and learning approaches, engage in peer learning and receive feedback that enables them to progress towards their learning objectives. However, such accounts of safety grounded in familiarity and structured learning experiences are challenged by evidence from clinical practice. Dafny et al.'s¹⁶ small interpretive study examining the perpetrators and impact of racism among second- and final-year nursing students on clinical placements suggests that racism is multi-faceted within clinical learning environments. Discriminatory experiences were reported as originating from patients, occurring between nurses and students, and being directed towards patients themselves. While shared ethnic backgrounds were sometimes associated with preferential treatment, differences relating to age, sex, language, religion and sexual orientation were also found to increase the likelihood of discrimination. These findings highlight that experiences of safety within clinical learning environments are unevenly distributed and influenced by social, cultural and interpersonal dynamics.

Safe learning environment charter

The United Kingdom's National Health Service (NHS England) introduced a safe learning environment charter (SLEC) in February 2024 to support the development of a positive safety culture underpinned by principles of equality, diversity and inclusion.¹⁷ The Charter comprises of ten elements (Table 1) and was designed for learners and those responsible for supporting placement learning with the purpose of

Table 1. Elements of the NHSE (2024) safe learning environment charter.

Element	Description
Respect and feeling valued	Learners are treated with respect and feel valued, demonstrated through effective communication and meaningful engagement
Positive identity	Learners are easily identified within the practice setting and are viewed positively as learners
Wellbeing	Learners understand the importance of physical, emotional and psychological safety, and are aware of services and resources that support health and wellbeing
Raising concerns and speaking up	Learners know how to raise concerns and feel empowered to speak up, with confidence that they will be listened to and appropriately supported
Placement induction	Learners receive a placement induction that supports learning and prepares them for their role within the practice environment
Communication	Clear and accessible pathways for support are provided by both the education provider and the placement provider
Flexibility	Learner wellbeing and professional development are supported through flexible working and learning practices, including accessibility to facilities and educational opportunities
Supervision	Learners are supported by positive role models and appropriate levels of supervision. Continuity of supervision builds on individual learning needs and develops confidence and proficiency
Teaching and learning needs	Learners are supported by supervisors who are adequately prepared for the role and understand principles of learning in practice settings. Learners are recognised as learners rather than workers and enabled to progress towards independent practice
Time and space for learning	Learners are given time to reflect on, and process learning experiences and receive regular verbal and written feedback to support development and assessment

Source: <https://www.england.nhs.uk/mat-transformation/safe-learning-environment-charter/>.

reinforcing the value of learners within the workforce. Although the SLEC adopts the term ‘learners’ to encompass the broad range of individuals undertaking practice-based education, this paper focuses primarily on pre-registration nursing students. The term ‘learner’ is therefore used where discussion relates to the charter more generally, whereas ‘students’ refers specifically to these groups.

The quality of the clinical, learning and working environment is linked to the experiences of students,^{18–20} and it is known to have an impact on the outcome of practice-based assessments^{21,22} and career destination.²³

Within the last two decades in the UK, there have been a series of high-profile ‘healthcare catastrophes’²⁴ where failures in the delivery of healthcare have resulted in poor clinical outcomes arising from patient safety errors. Successive official inquiries have recommended the creation of a positive learning culture²⁵ and a commitment to safer clinical learning environments.²⁶ The creation of the safe learning environment charter was triggered by feedback from students consulted as part of reviews into the safety of maternity services within England.^{27–30} Midwifery students reported not feeling valued and cited inconsistent supervision, role modelling and a lack of protected time for learning and reflection.³¹

Justice

Desert-based theories of justice argue that individuals should receive benefits based on conditions such as good behaviour that are proportionate to the action, effort and contribution made by the individual, or retribution based on poor conduct or when a wrongful act has been committed. Desert as a distributive ideal is said to be just because justice requires giving individuals what they deserve.

Rawls³² argued that justice is not the result of divine providence, but a human construction designed to benefit the least advantaged members of society. Within this framework, liberty depends upon equitable access to opportunity, irrespective of background, ensuring that individuals are able to participate meaningfully within democratic systems. Rawls contrasted this position with utilitarianism, in which morally right action is understood to maximise overall happiness and minimise suffering, and intuitionism, where decisions are guided by individual judgements of what is ‘right’. He argued that utilitarian approaches risk subordinating the rights of some to the greater good, while intuitionism may reinforce dependence on those perceived to hold greater knowledge or authority. A key element of the SLEC¹⁶ is wellbeing and access to support services for students who may have a disability or who are neurodivergent. The charter presupposes that learners are willing to disclose a perceived need and consent to being assessed to determine whether reasonable adjustments can be put in place. The tailoring of a personal support plan in the context of finite resources and the need to protect patient safety is an example of how a genuine commitment to social justice might be legitimately challenged when the ‘reasonableness’ of an adjustment is questioned.

For Rawls, the purpose of education is to address inequality by directing resources towards those who are most disadvantaged. His ‘difference principle’ further suggests that inequality may only be justified where it improves the position of the least advantaged. Applied to clinical learning environments, this raises important questions about how safety, support and opportunity are distributed among students, and whether the most vulnerable are adequately protected within practice-based education.

Mills³³ criticised Rawls and other social contract theorists as their model of justice ignored ‘baked-in’ inequality which rendered justice and fairness indistinguishable. A counterargument is that fairness within a modern society is deliverable through practices and procedures that result in a just outcome.

Desert

The notion of 'desert' is based on a person's entitlement when their actions deviate from their ordinary obligations and therefore attracts moral praise above that which would be recognised through ordinary compensation. Gibbs³⁴ asserted that desert had become problematic in a market-determined higher education system because the notion required considerations of personal justice and freedom at a time of instrumental student assessment. He argued that desert needed to be differentiated from what a person might need or merit. An entitlement based on an activity or achievement that superseded standards or criteria could be described as 'merit', whereas 'need' was the condition that enabled the exercise of human capability and was secured through physical and psychological health and freedom.

As an example, we might argue that a nursing student is entitled to merit based on their engagement in practice and ability to deliver care above the baseline standard of proficiency contained within their practice assessment document. The student's physical and psychological health and freedom to practice is a need, as it forms the necessary condition for them to demonstrate their full capabilities. The desert characterised by the praise received from their practice assessor is an entitlement by virtue of the student's actions deviating from their ordinary obligation to practice safely, effectively and efficiently and to demonstrate sound knowledge (which would guarantee they passed their placement) because they have practised above that baseline standard.

In this sense, desert cannot be understood simply in terms of rewards, entitlements or rights, which are typically defined through procedural, measurable and explicit criteria. Rather, claims of desert are grounded in more subjective moral judgements about what an individual is considered to deserve. This becomes problematic in practice education, where students are formally assessed against defined standards but are also expected to demonstrate moral and critical reasoning, qualities which are less easily measured and more open to interpretation.

Brigati³⁵ criticises the assumption that desert is a natural feature of an action, person or performance that occurs independently of the institution that rewards it and therefore the socio-political background against which it stands out. In contrast, he argues that desert should not be construed as a precondition for the foundation of a just society. Furthermore, he argued that desert and merit are not something natural prior to any social convention or institution rewarding it (the natural-desert thesis); or that desert is the defining condition of a just society (desert-as-foundation thesis) and that a just society is defined by a pattern of distribution according to desert and merit (the monotonic scheme thesis). Brigati³⁵ argues that desert needs to be understood in the context of social versus natural criteria based on political justice that promotes normative standards for the design of social institutions. When desert is viewed as some kind of reward, a rewarding party must exist and have reasons for its actions and operation. For example, a student is required to fulfil conventions, covenants, social rules and behaviour patterns which are in accordance with the desert. The SLEC could be described as covenantal by virtue of the tripartite expectation placed on learners, the host organisation and universities, which set against a bricolage of laudable elements, are said to ensure safety based on behaviour patterns. Brigati³⁵ argues that the fortune of a desert is based on a theory that regards good as both natural and normative. In which case a nursing student's performance is meritorious in of itself, precisely because it corresponds to the ends or values held by the practice supervisor or assessor as their actions are internally connected to what Brigati refers to as an appropriate, dutiful response in terms of approval or disapproval. Therefore, a student may receive desert despite the quality or relative safety of a learning environment as the desert is contingent on the instrumentality of the practice assessment.

The absence of an ethical community or a shared need for the regulation of behaviour removes the grounds on which there is a connection between the ability of the student to claim a desert as the ethical community must possess a 'desert-core' which should act as a stimulus for student practice. The SLEC appears to outline a framework that tacitly conveys a desert core that may or may not exist or even be

realistically deliverable within the particular clinical environment that the nursing student finds themselves within. Brigati³⁵ concludes that the merit of any action is a matter of interpretation and reflection, not for spontaneous reaction of approval or disapproval or the extent to which an action is intentionally meritorious as (in the case of a nursing student) it should make a difference to the patient as well as the student. Therefore, desert as a natural and inherent feature of practice needs to be seen in the context of the meritorious good that results to wider society, health and patient care. Interestingly, with the exception of raising concerns in practice, the SLEC makes no reference to clinical or patient outcomes, which as discussed earlier, are closely associated with strong learning cultures and the attainment of an expert level of performance.^{35,36}

Nursing students within the UK are assessed against criteria which is based on a model of participatory learning, where progression is confirmed by a practice assessor who has the right to contact a previous assessor, in addition to current practice supervisors, when coming to an assessment decision.³⁷ Morrison³⁸ argues that the logic of desert operates at the intersection of a retrospective consideration of the virtue of past action and a future-oriented utilitarian consideration of the achievement of the learner, as the student deserves to be assessed on their actions and receive formal recognition through an appropriately valid academic award based on credentialism. He also argues that such an intersection is problematic in the context of the workplace, as intelligence, aptitude and resilience are socially conditioned. Evans³⁹ describes the problematic, liminal nature of clinical nursing where obligation to patient safety and selflessness form a self-narrative that creates a nurse's identity as a knowledgeable practitioner. When learners are confronted with ways of thinking that determine disciplinary knowledge, a liminal space occurs where key events characterised by uncertainty shape the life course of the learner. In trying to understand why an individual becomes deserving of something, Morrison³⁸ asserts that the basis of the desert rests on the idea that an individual should receive a certain thing (be it a reward or punishment) because there is a certain propriety in them having it – desert requires a kind of propriety that is distinguishable from other types of propriety such as entitlement, as mere entitlement rests on the formal rules-based satisfaction of certain criteria. Therefore, the propriety of desert pertains to meeting certain unwritten or tacit conditions of 'worthiness'. The basis by which a UK nursing student is deemed able to progress through all three 'parts' of the practice assessment document³⁹ rests on a process of confirmation that includes a consideration of a student's professional values. If a student is to deserve a safe learning environment, their desert must be by virtue of some relevant fact about them, for example, their current proficiency or earlier performance. Interestingly, the value of a student's ability to embrace a safe learning environment may enable them to demonstrate social credentialism through work-readiness, rather than the credentialism associated with the attainment of a good degree, as the students performability is reconceptualised through the dimensions of their soft skills, inclusive practice and therefore their employability.⁴⁰

Problematic nature of learning

Learning within practice settings is reliant on participation through engagement '...with others and in activities that have social genesis...understood through the concept of participatory practices',⁴¹ where the unknown or unfamiliar is assimilated. When this process is disrupted, the learner experiences disequilibrium as the learner is unable to reconcile the experience with what is known and familiar. Jarvis⁴² describes the disharmony that occurs when learners do not know how to act in 'a magic moment that stops us in our tracks' (pg. 20, 2009). These abnormal or supranormal experiences that give rise to astonishment and wonder may also result in unease within experiences where time appears to stop and the learner's biographical repertoire is no longer able to cope within novel situations. Webster-Wright's research⁴³ on workplace learning within physiotherapy similarly illustrates how professional learning may become constrained when organisational priorities are perceived to take precedence over opportunities for reflection and professional development. Physiotherapists reported feeling primarily valued for their contribution to

organisational efficiency and productivity, creating a dissonance within their professional lifeworld. This organisational tension mirrors the disjuncture described by Jarvis,⁴¹ where learners must reconcile competing educational and workplace expectations. Within clinical learning environments, such tensions may therefore become an important component of professional formation, provided they occur within learning cultures that support reflection, supervision and psychological safety rather than fear or exclusion. Such findings are pertinent to discussions of safe clinical learning environments because they highlight how learning may be constrained when organisational imperatives take precedence over opportunities for reflection, identity formation and engagement with challenging experiences that are central to professional development.

Considerations for practice

The analysis presented in this paper suggests that the SLEC should not simply be interpreted as a procedural framework for protecting students, but as an invitation to reconsider the ethical and educational conditions under which practice learning occurs.

A first consideration concerns the relationship between safety and professional identity formation. Learning in clinical settings inevitably involves encounters with uncertainty, ethical tension in decision-making and emotional challenge. Experiences of disjuncture, as described by Jarvis,⁴¹ may represent critical moments in which learners confront the limits of their existing knowledge and assumptions. The aim of a safe learning environment, therefore, cannot be to remove these experiences entirely. Instead, the challenge for practice educators is to ensure that such encounters occur within relationships and organisational cultures that allow learners to process and reflect on them without fear of humiliation, exclusion or punitive consequences.

A second consideration relates to the translation of policy ideals into complex clinical environments. Settings such as emergency departments, forensic services, high-acuity units and pre-hospital care are characterised by unpredictable workloads, exposure to trauma and rapidly changing priorities. Limitations may arise in such environments where staffing pressures, patient acuity, resource constraints and competing clinical priorities shape the conditions in which supervision and learning occur. These contextual factors may also have implications for practice supervisors and assessors who are expected to support students whilst simultaneously managing demanding clinical responsibilities and their own professional development. In these contexts, the elements of the charter may be difficult to realise in a uniform manner. Rather than assuming that safe learning environments can be standardised across all settings, practice partners and universities may need to consider how the principles of the charter can be interpreted in ways that recognise the realities of particular clinical contexts. Encouraging nursing students to disclose a disability or specific learning need before practice learning begins, whether in simulated or placement settings, exemplifies the shared responsibility of learners, practice partners and universities in creating safe clinical learning environments. Working collaboratively enables appropriate support to be implemented while protecting both the student's learning experience and the integrity of the SLEC.

A further consideration concerns the accountability for maintaining safe learning environments. The analysis of desert-based justice suggests that learning cultures may implicitly position safety as something students must negotiate through resilience, conformity or professional credibility. If this is the case, the ethical responsibility for safe learning environments risks being displaced onto those with the least institutional authority. The implementation of the charter therefore raises important questions about how responsibility is practically distributed between universities, placement providers and the clinical teams who supervise learners.

Finally, the charter invites reflection on the role of practice learning in preparing students to engage with the broader social realities that shape health and healthcare. Clinical placements frequently expose learners

to forms of social injustice, inequality and structural vulnerability that underpin major public health challenges. While such encounters may generate discomfort or moral unease, they may also play an important role in the development of professional judgement, ethical and situational awareness and commitment to patient advocacy. Supporting students to engage critically with these experiences may therefore represent an important dimension of safe and meaningful practice learning.

Conclusion

The question of whether students should be protected from challenging or unsettling experiences is ethically and pedagogically significant. Shielding learners from the realities of inequality, moral uncertainty and injustice that shape contemporary healthcare may risk removing the very authentic experiences through which professional understanding develops. Experiences of ‘unquiet’, described by Jarvis⁴² as moments of learning disjuncture characterised by disequilibrium, may therefore represent important opportunities for reflection and growth. In this respect, engagement with such experiences reflects Rawls⁵ difference principle, whereby confronting inequality and disadvantage contributes to the ethical formation of healthcare professionals and supports the development of a more just practice culture. Rather than viewing safety and challenge as opposing concepts, this paper argues that safe CLEs should enable learners to engage constructively with uncertainty, supported by relationships and organisational cultures that facilitate reflection, inclusion and professional growth. The analysis presented in this paper suggests that safer CLEs are unlikely to be achieved through procedural safeguards and policies alone. Rather, the principles contained within the SLEC may be most effective when they support the development of ethical learning communities characterised by inclusive relationships, psychological safety, meaningful supervision and opportunities for critical reflection. Such environments do not seek to eliminate uncertainty, challenge or learning disjuncture, but instead, enable learners to engage with these experiences in ways that promote professional growth, ethical awareness and the development of sound clinical judgement. In this sense, the Charter may be understood not simply as a framework for protection, but as a mechanism for fostering ethical, relational and educational conditions through which safe, just and transformative practice learning can occur.

ORCID iD

Mark Philip Wareing  <https://orcid.org/0000-0002-0968-5558>

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Declaration of conflicting interests

The Editor in Chief, Professor Ann Gallagher, is line manager of the corresponding author.

References

1. Pienaar M, Orton AM and Botma Y. A supportive clinical learning environment for undergraduate students in health sciences: an integrative review. *Nurse Educ Today* 2022; 119: 105572. <https://doi.org/10.1016/j.nedt.2022.105572>
2. Thomas CA. Stifled learning nursing students’ experience of incivility in clinical education. *J Christ Nurs* 2018; 35: 106–111. <https://doi.org/10.1097/CNJ.0000000000000477>
3. Hardie P, O’Donovan R, Jarvis S, et al. Key tips to providing a psychologically safe learning environment in the clinical setting. *BMC Med Educ* 2022; 22: 816. <https://doi.org/10.1186/s12909-022-03892-9>

4. Kempen E, Labuschagne MJ and Jama MP. Elements of a safe learning environment: a student perspective. *African Journal of Health Professions Education* 2024; 16: e1222, Available from: <https://doi.org/10.7196/AJHPE.2024.v16i2.1222>
5. Rawls A. A theory of justice with claims of desert. *Indepen Rev* 2021; 26(3): 333–360.
6. Jackson N and Barnett. *Ecologies for learning and practice emerging ideas, sightings, and possibilities*. 1st ed. Routledge, 2020, p. 254.
7. Tupper H and Ellis S. *How to help your team learn in the flow of work*. Learning and Performance Institute, 2023.
8. Abate LE and Greenberg L. Incivility in medical education: a scoping review. *BMC Med Educ* 2023; 23: 24. <https://doi.org/10.1186/s12909-022-03988-2>
9. Milligan F, Wareing M, Preston-Shoot M, et al. Supporting nursing, midwifery and allied health professional students to raise concerns with the quality of care: a review of the research literature. *Nurse Educ Today* 2017; 57: 29–39. <https://doi.org/10.1016/j.nedt.2017.06.006>
10. Anderson J. Providing a safe learning environment for queer students in Canadian schools: a legal analysis of homophobic bullying. *J LGBT Youth* 2014; 11: 212–243. <https://doi.org/10.1080/19361653.2013.879463>
11. Rogers CR. *Client-centered therapy; its current practice, implications, and theory*. Houghton Mifflin, 1951; p xii: 560.
12. Banks JA. Diversity, group identity, and citizenship education in a global age. *Educ Res* 2008; 37: 129–139. <https://doi.org/10.3102/0013189x08317501>
13. Freire P. *Pedagogy of the oppressed*. Continuum, 1993.
14. Hagerty BM, Lynch-Sauer J, Patusky KL, et al. An emerging theory of human relatedness. *Image J Nurs Sch*. 1993 Winter 1993; 25(4): 291–296, PMID: 8288296: <https://doi.org/10.1111/j.1547-5069.1993.tb00262.x>
15. Henríquez VV, Rabanal IC and Abásolo JS. Applying Kolb’s experiential learning cycle for deep learning: a systematic literature review. *Soc Sci Humanit Open* 2025; 12: 102096. <https://doi.org/10.1016/j.ssaho.2025.102096>
16. Dafny HA, Snaith N, McCloud C, et al. Racism during clinical placement, the perpetrators, impact, advocating and reporting. *Nurs Ethics* 2025; 32: 1886–1899. <https://doi.org/10.1177/09697330251317675>
17. NHS England. *Safe learning environment charter*. NHS England, 2024.
18. Jack K, Hamshire C, Harris WE, et al. “My mentor didn’t speak to me for the first four weeks”: perceived unfairness experienced by nursing students in clinical practice settings. *J Clin Nurs* 2018; 27: 929–938. <https://doi.org/10.1111/jocn.14015>
19. Clements AJ, Kinman G, Leggetter S, et al. Exploring commitment, professional identity, and support for student nurses. *Nurse Educ Pract* 2016; 16: 20–26. <https://doi.org/10.1016/j.nepr.2015.06.001>
20. Courtney-pratt H, Pich J, Levett-jones T, et al. “I was yelled at, intimidated and treated unfairly”: nursing students’ experiences of being bullied in clinical and academic settings. *J Clin Nurs* 2018; 27: e903–e912. <https://doi.org/10.1111/jocn.13983>
21. Burgess A and Mellis C. Feedback and assessment for clinical placements: achieving the right balance. *Adv Med Educ Pract* 2015; 6: 373–381. <https://doi.org/10.2147/AMEP.S77890>
22. Wongtongkam N and Brewster L. Effects of clinical placements on paramedic students’ learning outcomes. *Asia Pac J Health Manag* 2017; 12(3): 24–31, Available from: <https://doi.org/10.24083/apjhm.v12i3.55>
23. Wareing M, Taylor R, Wilson A, et al. The influence of placements on adult nursing graduates’ choice of first post. *Br J Nurs* 2017; 26(4): 228–233. <https://doi.org/10.12968/bjon.2017.26.4.228>
24. Roberts M and Ion R. A critical consideration of systemic moral catastrophe in modern health care systems: a big idea from an Arendtian perspective. *Nurse Educ Today* 2014; 34: 673–675. <https://doi.org/10.1016/j.nedt.2014.01.012>
25. Berwick D. *A promise to learn – a commitment to act: improving the safety of patients in England*. Department of Health, 2013.

26. Nordquist J, Hall J, Caverzagie K, et al. The clinical learning environment. *Med Teach* 2019; 41: 366–372. <https://doi.org/10.1080/0142159X.2019.1566601>
27. Kirkup B. *The report of the morecambe Bay investigation*. The Stationery Office, 2015.
28. Kirkup B. *Reading the signals: maternity and neonatal services in east Kent – the report of the independent investigation*. The Stationery Office, 2022.
29. Ockenden D. *Emerging findings and recommendations from the independent review of maternity services at the shrewsbury and Telford Hospital NHS trust*. London: Her Majesty's Stationery Office, 2020.
30. Ockenden D. *Final report of the independent review of maternity services at the shrewsbury and Telford Hospital NHS trust*. London: Her Majesty's Stationery Office, 2022.
31. Grimwood T, Snell L and Hitchen S. Review of midwifery education and training and newly qualified experience: thematic analysis. *Health and Society Knowledge Exchange (HASKE)*. 2023.
32. Rawls J. *A theory of justice*. Rev ed. Harvard University Press, 1999.
33. Mills CW. *The racial contract*. 25th anniversary ed. Cornell University Press, 2022, p. 216.
34. Gibbs P. Who deserves foundation degrees? *J Furth High Educ* 2002; 26: 197–206. <https://doi.org/10.1080/03098770220149567>
35. Brigati R. Desert as a principle of distributive justice: a reconsideration. *Philos Soc Critic* 2014; 40: 705–722. <https://doi.org/10.1177/0191453714536434>
36. Dochy F, Gijbels D, Segers M, et al. *Theories of learning for the workplace. Building blocks for training and professional development programs*. 1st ed. Routledge, 2011, p. 168.
37. Nursing and Midwifery Council. *Standards for student supervision and assessment*. NMC, 2023.
38. Morrison A. Just deserts? Grade inflation and desert-based justice in English higher education. *Br J Educ Stud* 2020; 69: 437–451. <https://doi.org/10.1080/00071005.2020.1832957>
39. Evans K. Liminality, uncertainty and troublesome knowledge in learning at work. In: Bound H, Edwards A, Evans K, et al. (eds). *Workplace Learning for Changing Social and Economic Circumstances*. Routledge, 2023.
40. Pan London Practice Learning Group, London Nursing Pan and London Nursing Associate. London, Pan London Practice Learning Group. 2026. At: <https://plplg.uk/nursing-na-epad/>
41. Billett S, Barker M and Hernon-Tinning B. Participatory practices at work. *Pedagogy, Culture & Society*, 2004, vol 12, p. 233.
42. Jarvis P. *Learning to be a person in society*. 1st ed. Routledge, 2009, p. 240.
43. Webster-Wright A. *Authentic professional Learning- making a difference through learning at work*. 1st ed. Springer, 2010, p. 260.