Glossary

Blinding (masking): in an experimental study, refers to whether patients, clinicians providing an intervention, people assessing outcomes, and/or data analysts were aware or unaware of the group to which patients were assigned. In the methods section of *Evidence-Based Nursing* abstracts of treatment studies, the study is identified as blinded, with specification of who was blinded; unblinded, if all parties were aware of patients' group assignments; or unclear if the authors did not report or provide us with an indication of who was aware or unaware of patients' group assignments.

Concealment of randomisation: concealment of randomisation is specified in the methods section of *Evidence-Based Nursing* abstracts of treatment studies as follows: allocation concealed (deemed to have taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, central randomisation; sequentially numbered, opaque, sealed envelopes; sealed envelopes from a closed bag; numbered or coded bottles or containers; drugs prepared by the pharmacy; or other descriptions that contain elements convincing of concealment]); allocation not concealed (deemed to have not taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, no concealment procedure was undertaken, sealed envelopes that were not opaque or were not sequentially numbered, or other descriptions that contained elements not convincing of concealment]); unclear allocation concealment (the authors did not report or provide a description of an allocation concealment approach that allowed for the classification as concealed or not concealed).

Confidence interval (CI): quantifies the uncertainty in measurement; usually reported as 95% CI, which is the range of values within which we can be 95% sure that the true value for the whole population lies.

Effect size¹: a measure of effect that is typically used for continuous data when different scales are used to measure an outcome and is usually defined as the difference in means between the intervention and control groups divided by the standard deviation of the control or both groups; it can be used for combining results across studies in a meta-analysis.

Ethnography (ethnographic study)²: an approach to inquiry that focuses on the culture or subculture of a group of people, with an effort to understand the world view of those under study.

Factorial design²: a design where 2 independent variables are simultaneously manipulated; permits analysis of the main effects of the independent variables separately plus the interaction of these variables.

Fixed-effect model¹: gives a summary estimate of the magnitude of effect in meta-analysis. It takes into account within-study variation but not between-study variation and hence is usually not used if there is significant heterogeneity.

Grounded theory²: an approach to collecting and analysing qualitative data with the aim of developing theories grounded in real world observations.

Hazard ratio³: the weighted relative risk over the entire study period; often reported in the context of survival analysis.

Intention-to-treat analysis (ITT): all patients are analysed in the groups to which they were randomised, even if they failed to complete the intervention or received the wrong intervention.

Number needed to harm (NNH)⁴: number of patients who, if they received the experimental treatment, would lead to 1 additional person being harmed compared with patients who receive the control treatment; this is calculated as 1/absolute risk increase (rounded to the next whole number), accompanied by the 95% confidence interval.

Number needed to treat (NNT): number of patients who need to be treated to prevent 1 additional negative event (or to promote 1 additional positive event); this is calculated as 1/absolute risk reduction (rounded to the next whole number), accompanied by the 95% confidence interval.

Odds ratio (**OR**): describes the odds of a patient in the experimental group having an event divided by the odds of a patient in the control group having the event *or* the odds that a patient was exposed to a given risk factor divided by the odds that a control patient was exposed to the risk factor.

Random-effects model¹: gives a summary estimate of the magnitude of effect in meta-analysis. It takes into account both within-study and between-study variance and gives a wider confidence interval to the estimate than a fixed-effects model if there is significant between-study variation.

Relative benefit increase (RBI): the proportional increase in the rates of good events between experimental and control participants; it is reported as a percentage (%).

Relative risk (RR): proportion of patients experiencing an outcome in the treated (or exposed) group divided by the proportion experiencing the outcome in the control (or unexposed) group.

Relative risk increase (RRI): the proportional increase in bad outcomes between experimental and control participants; it is reported as a percentage (%).

Relative risk reduction (RRR): the proportional reduction in bad outcomes between experimental and control participants; it is reported as a percentage (%).

Standardised mean difference¹: in a systematic review, a way of combining the results of studies that may have measured the outcome (eg, pain) in different ways, using different scales; effects are expressed as a standard value, with no units (difference between 2 means / estimate of within-group standard deviation).

Weighted mean difference¹: in a meta-analysis, used to combine outcomes measured on continuous scales (eg, height), assuming that all trials measured the outcome on the same scale; the mean, standard deviation, and sample size of each group are known, and weight given to each trial is determined by the precision of its estimate of effect.

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