**Glossary**

**Adjusted analysis**: when groups differ on baseline characteristics (eg, age), analyses of outcome data are statistically modified to account for these differences.

**Blinding (masking)**: in an experimental study, refers to whether patients, clinicians providing an intervention, people assessing outcomes, and/or statisticians were aware or unaware of the group to which patients were assigned. In the design section of Evidence-Based Nursing abstracts of treatment studies, the study will be identified as blinded, with specification of who was blinded; unblinded, if all parties were aware of patients’ group assignments; or blinded (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 design 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]; 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 other descriptions that contain 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.

**Crossover trial**: a method of comparing 2 interventions in which patients are switched to the alternative intervention after a specified period of time.

**Dose response**: indicates that a relation exists, such that increasing doses or duration of treatment results in increased frequency or intensity of outcomes (eg, as the dosage of a medication increases, so does the magnitude of pain reduction).

**Fixed effects model**: 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 theory**: an approach to collecting and analysing qualitative data with the aim of developing theories grounded in real world observations.

**Hermeneutic phenomenology**: the study of the methodological principles of interpretation by using narrative texts to explain a phenomenon.

**Heterogeneity**: the degree to which the effect estimates of individual studies in a meta-analysis differ significantly.

**Inductive analysis**: often used in qualitative research, this type of analysis begins with specific observations from which generalisations are developed; opposite to deductive analysis, often used in quantitative research, which begins with the abstract (eg, general laws or hypotheses) from which logical deductions about specific things are made.

**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.

**Logistic regression**: a statistical technique that predicts the probability of a dichotomous dependent variable (eg, dead or alive) using, typically, a combination of continuous and categorical independent variables.

**Meta-analysis**: a method for combining the results of several independent studies so that an overall summary statistic can be calculated.

**Multiple case study approach**: a non-experimental study design involving a series of cases; the cases may be individuals, groups, or organisations; data are collected and analysed from these multiple sources (cases).

**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.

**Phenomenology**: an approach to inquiry that emphasises the complexity of human experience and the need to understand that experience holistically as it is actually lived.

**Power**: the ability of a study to detect an actual effect or difference of a given size (eg, a 10% difference) between groups; it has to do with the adequacy of sample size. Before a study begins, researchers often calculate the number of participants required to detect a postulated difference between 2 groups. If a study has insufficient power (ie, sample size is too small), actual differences between groups may not be detected.

**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 reduction (RRR)**: the proportional reduction in outcome rates of bad events between experimental and control participants; it is reported as a percentage (%).

**Weighted**: statistical analysis accounts for differences in certain important variables.