

Appendix A: Glossary of terms

Acute pain: Pain that occurs suddenly, starts out as sharp or intense, and serves as a warning sign of disease or threat to the body. Acute pain tends to be caused by injuries, illness, surgeries or other painful medical procedures or traumas. Acute pain lasts less than six months, and usually disappears when the underlying cause is treated or healed (24).

Best practice guidelines (BPG): “Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policy makers, persons and their families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people and communities and the health system” (146).

Best Practice Spotlight Organization® (BPSO®): A health service or academic organization that has formally partnered with RNAO over a three-year period to create evidence-based practice cultures through the systematic implementation and outcome evaluation of multiple best practice guidelines (BPGs) (147).

Caregivers: An individual that provides physical, psychological and emotional support, as deemed important by the person receiving care. This care can include support in decision making, care coordination and continuity of care. Caregivers can include family members, close friends or other individuals and they are identified by the person receiving care or substitute decision maker (148).

*The term care partner may also be used commonly in practice

Chronic pain: Pain that persists or recurs for longer than three months, and often becomes the sole or predominant clinical problem in some people (25). Chronic pain is multifactorial: biological, psychological and social factors contribute to the pain syndrome (25). The *International Classification of Diseases, Eleventh Revision (ICD-11)*, by the World Health Organization (WHO) breaks chronic pain into the following sub-types of chronic pain: chronic primary pain, chronic cancer related pain, chronic post-surgical or post traumatic pain, chronic secondary musculoskeletal pain, chronic secondary visceral pain, chronic neuropathic pain and chronic secondary or orofacial pain (25).

Comprehensive pain assessment: A comprehensive pain assessment is completed with anyone having the presence, or risk of, any type of pain. The comprehensive pain assessment permits the health provider to elicit the person’s subjective report of pain, including the sensory, psychologic, cultural, and emotional aspects of their pain experience and understand the impact this has on the person’s life. A mnemonic is often used to articulate the components of a comprehensive pain assessment such as the PQRSTU or OPQRSTUV tools (58).

Cultural safety: “Cultural safety is about the experience of the patient. It is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health-care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care” (149).

Evidence-based practice: The integration of research evidence with clinical expertise and patient values. It unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (150).

Evidence-to-Decision (EtD) frameworks: A table that helps guideline panels make decisions when moving from evidence to recommendations. The purpose of the Evidence-to-Decision framework (EtD) is to summarize the research evidence, outline important factors that can determine the recommendation, inform panel members about the benefits and harms of each intervention considered, and increase transparency about the decision-making process in the development of recommendations (13).

External reviewer: Individuals or groups who commit to reviewing and providing feedback on the draft RNAO best practice guideline prior to publication. External reviewers often include individuals or groups directly impacted by the guideline topic and recommendations (e.g., people accessing health services, people working in health service organizations or people with subject-matter expertise).

Families/Family: A term used to refer to individuals who are related to (biologically, emotionally or legally) and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person receiving health care. A person's family includes all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities and populations). The person receiving care determines the importance and level of involvement of any of these individuals in their care based on his or her capacity" (151).

Good practice statement: Good practice statements are directed primarily to nurses and the interprofessional teams that provide care to persons and their families across the continuum of care, including (but not limited to) primary care, home and community care, acute care and long-term care.

Good practice statements are actionable statements that should be done in practice (8). These are believed to be so beneficial that summarizing the evidence would be a poor use of the expert panel's time and resources (8). Moreover, researchers may no longer be conducting studies on the topic, or the alternative to the action may be unethical or studying them may go against human rights (8,9). Given the high level of certainty that the benefits derived from the good practice statement outweigh the harms, they are not based on a systematic review of the evidence and do not receive a rating of the certainty in their evidence or a strength (i.e., a rating of conditional or strong, which is further discussed below) (10). This does not diminish certainty in the evidence. While they are often supported by indirect evidence, there is a well-documented, clear and explicit rationale connecting the indirect evidence to the statement (8). As such, good practice statements should be interpreted as strong recommendations as there is an underlying assumption that there is high certainty in the benefits of implementing the action (8).

Grading of Recommendations Assessment, Development and Evaluation (GRADE): A methodological approach to assess the certainty of a body of evidence in a consistent and transparent way and to develop recommendations systematically. The body of evidence across identified important and/or critical outcomes is evaluated based on the risk of bias, consistency of results, relevance of studies, precision of estimates, publication bias, large effect, dose-response and opposing confounding (13).

When using GRADE, five components contribute to the assessment of confidence in the evidence for each outcome. These components are as follows:

1. Risk of bias: Focuses on flaws in the design of a study or problems in its execution.
2. Inconsistency: Examines a body of evidence and assesses whether the results point in the same direction or are different.
3. Imprecision: Refers to the accuracy of results based on the number of participants and/or events included, and the width of the confidence intervals across a body of evidence.
4. Indirectness: Each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention and outcome outlined in the research question.
5. Publication bias: A decision about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (13).

Health equity: Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically, or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability or sexual orientation). Health equity is achieved when everyone can attain their full potential for health and well-being (152).

Health provider: Refers to regulated (e.g., nurses, physicians, dietitians, social workers) and unregulated (e.g., personal support workers) workers who are part of the interprofessional team.

Regulated health provider: In Ontario, the *Regulated Health Professional Act, 1991* (RHPA) provides a framework for regulating 26 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (153).

Unregulated health provider: Unregulated health providers fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (such as the College of Nurses of Ontario). Unregulated health providers fulfill their roles and tasks determined by their employers. They are referred to as unregulated care providers (UCPs), depending on the practice setting (e.g., long-term care). Unregulated health providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (154).

Health service organizations: Organizations delivering health-care services to defined communities or populations. This includes, but is not limited to, family health teams, community health centres, home care organizations and hospitals.

Implementation science: “The scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care” (155).

Indigenous: Introduced and used in a global context following the international efforts of Aboriginal peoples to achieve a greater presence in the United Nations (UN). The UN broadly defines Indigenous persons as peoples of long settlement and connection to specific lands who practise unique traditions and retain social, cultural, economic and political characteristics distinct from those of the dominant societies in which they reside (156). Under the UN definition, Indigenous is generally understood to include the following: self-identification at the individual level and acceptance by an Indigenous community as a member; historical continuity with pre-colonial or pre-settler societies; strong links to territories and surrounding natural resources; distinct social, economic or political systems; and distinct language, culture and beliefs. Indigenous peoples form non-dominant groups within society and resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities (156).

The Canadian Constitution recognizes three groups of Indigenous peoples: First Nations, Inuit and Métis. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs (157).

Integrative approach to pain: An integrative approach to pain prevention, assessment and management acknowledges the complexity and biopsychosocial nature of the pain experience and involves health providers creating an individualized, person- and family-centred plan of care that combines treatment strategies to include both pharmacological and non-pharmacological pain interventions (NPI) (73).

Interprofessional team: A team comprised of multiple health providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health services to persons within, between and across health-care settings (7). Key interprofessional team members supporting people experiencing pain may include nurses, general practitioners, physicians, dietitians and pharmacists. It is important to emphasize that persons and their family are at the centre of the interprofessional team as active participants.

Meta-analysis: A systematic review that uses statistical methods to analyze and summarize the results of the included studies (158).

See systematic review

Mixed pain: An evolving concept currently defined as a “complex overlap of the different known pain types (e.g., nociceptive, neuropathic and nociplastic) in any combination, acting concurrently and/or simultaneously to cause pain in the same body area. Either mechanism may be more clinically predominant at any point in time. Mixed pain can be acute or chronic” (26).

Neuropathic pain: Pain that is caused by a lesion or disease of the somatosensory nervous system (17).

Nociceptive pain: Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors (17).

Nociplastic pain: Pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain (17).

Non-pharmacological interventions for pain management (NPI): Interventions to prevent and/or manage any type of pain that do not involve using pharmacological medication.

Non-randomized study (NRS): A quantitative study that estimates an intervention’s effectiveness. Participants are allocated to different interventions using methods that are not random (158).

Nurse: Refers to registered nurses, licensed practical nurses (referred to as “registered practical nurses” in Ontario), registered psychiatric nurses and nurses in advanced practice roles, such as nurse practitioners and clinical nurse specialists (153).

Outcomes: A dependent variable, or the clinical and/or functional status of a patient or population, used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on whether they are (a) critical for decision making, (b) important but not critical for decision making, or (c) not important. The use of these outcomes helps make literature searches and systematic reviews more focused (13).

Pain: “An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage”. Pain is both complex and multifactorial (86).

Pain assessment: “The systematic process of evaluating and quantifying a person’s experience of pain. Gathering information from patients about their pain experience is essential to better understand and manage it. This process relies on self-reported information, standardized scales and tools, non-verbal cues, and consideration of various dimensions of pain, including its impact on the patient’s life. Accurate pain assessment also considers pain’s location, impact, and cultural factors, ultimately guiding tailored treatments for improved pain management and overall patient care” (28). There are a variety of tools that providers use to assess pain (159).

Pain management: The use of pharmacological and non-pharmacological interventions to control the person’s identified pain. Pain management includes the interprofessional health team and extends beyond pain relief, encompassing the person’s quality of life, ability to work productively, enjoy recreation, function normally in the family and society, and die with dignity (160).

Pain prevention: Focuses on evidence-based primary, secondary and tertiary pain prevention strategies and interventions.

- Primary prevention focuses on strategies and interventions to prevent acute pain, such as post-surgical pain (e.g., pharmacotherapy, physiotherapy, massage, relaxation and education).
- Secondary strategies focus on preventing the development of chronic pain (e.g., time-contingent exercise and medication).
- Tertiary pain prevention focuses on strategies to reduce the impact of chronic pain (e.g., interprofessional pain teams) (28).

Pain screening: A process of determining the presence or absence of any type of pain. If screening for pain identifies the presence of pain, then a more detailed and comprehensive pain assessment of this pain reporting is required (161).

Person: An individual with whom a health or social service provider has established a therapeutic relationship for the purpose of partnering for health. Replaces the terms “patient,” “client” and “resident” used across health and social service organizations (151).

Person- and family-centred care: An “approach to care [demonstrating] certain practices that put the person and their family members at the centre of health care and services. Person- and family-centred care respects and empowers individuals to be genuine partners with health-care providers for their health” (151).

Persons with lived experience: Members of the community who have first-hand experience and knowledge of the topic of interest either as a person, unpaid caregiver or advocate. Persons with lived experience are a diverse group with various backgrounds and experiences (162).

PICO research question: A framework to outline a focused question. It specifies four components:

- Patient or population that is being studied.
- Intervention to be investigated.
- Comparison or alternative intervention.
- Outcome of interest (13).

Quantitative research: A research approach that investigates phenomena with tools that produce statistical measurements/numerical data (163).

Randomized controlled trial (RCT): An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (158).

Recommendation: A course of action(s) that directly answers a recommendation question (also known as a “PICO research question”). A recommendation is based on a systematic review of the literature and is made in consideration of its (a) benefits and harms (b) values and preferences and (c) health equity. All recommendations are given a strength, either *strong* or *conditional*, through panel consensus.

It is important to note that recommendations should not be viewed as dictates, because they cannot take into account all of the unique features of individual, organizational and clinical circumstances (13).

Recommendation question: A priority research area of practice, policy or education identified by expert panel members that requires evidence to answer. The recommendation question may also aim to answer a topic area around which there is ambiguity or controversy. The recommendation question informs the research question, which guides the systematic review.

Self-management: Often associated with self-care and includes various activities that persons undertake to live well with one or more chronic conditions (164).

Systematic review (SR): A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (158).

See meta-analysis