**Supplemental Digital Content 2: MASTER safeguards not used in design-specific checklists**

**Missing MASTER scale safeguards in the JBI critical appraisal tools**

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| 1. | Data collected after the start of the study was not used to exclude participants or to select them into the analysis |
| 3. | Determination of eligibility and assignment to treatment group/exposure strategy were synchronised  |
| 4. | None of the eligibility criteria were common effects of exposure and outcome |
| 6. | Missing data was less than 20%  |
| 7. | Analysis accounted for missing data |
| 8. | Exposure variations/treatment deviations were less than 20%  |
| 16. | Analyst(s) were blinded  |
| 19. | Control and active interventions/exposures were sufficiently distinct  |
| 22. | The time period between exposure and outcome was similar across patients and between groups or the analyses adjusted for different lengths of follow-up of patients |
| 28. | Conflict of interests were declared and absent  |
| 30. | Computation errors or contradictions were absent |
| 31. | There was no discernible data dredging or selective reporting of the outcomes |
| 33. | Carry-over or refractory effects were avoided or considered in the design of the study or were not relevant |
| 35. | Dose of intervention/exposure was sufficient to influence the outcome |

**Missing MASTER scale safeguards in the SIGN critical appraisal tools**

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| 1. | Data collected after the start of the study was not used to exclude participants or to select them into the analysis |
| 3. | Determination of eligibility and assignment to treatment group/exposure strategy were synchronised  |
| 4. | None of the eligibility criteria were common effects of exposure and outcome |
| 6. | Missing data was less than 20%  |
| 7. | Analysis accounted for missing data |
| 8. | Exposure variations/treatment deviations were less than 20%  |
| 10. | Procedures for data collection of covariates were reliable and the same for all participants |
| 14. | Participants were blinded |
| 15. | Caregivers were blinded |
| 16. | Analyst(s) were blinded  |
| 17. | Care was delivered equally to all participants  |
| 18. | Cointerventions that could impact the outcome were comparable between groups or avoided  |
| 20. | Exposure/intervention definition was consistently applied to all participants |
| 21. | Outcome definition was consistently applied to all participants |
| 22. | The time period between exposure and outcome was similar across patients and between groups or the analyses adjusted for different lengths of follow-up of patients |
| 24. | Key confounders addressed through design or analysis were not common effects of exposure and outcome  |
| 28. | Conflict of interests were declared and absent  |
| 30. | Computation errors or contradictions were absent |
| 31. | There was no discernible data dredging or selective reporting of the outcomes |
| 33. | Carry-over or refractory effects were avoided or considered in the design of the study or were not relevant |
| 34. | The intervention/exposure period was long enough to have influenced the study outcome  |
| 35. | Dose of intervention/exposure was sufficient to influence the outcome |
| 36. | Length of follow-up was not too long or too short in relation to the outcome assessment  |

**Missing MASTER scale safeguards in the Newcastle-Ottawa Scale**

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| 1. | Data collected after the start of the study was not used to exclude participants or to select them into the analysis |
| 3. | Determination of eligibility and assignment to treatment group/exposure strategy were synchronised  |
| 6. | Missing data was less than 20%  |
| 7. | Analysis accounted for missing data |
| 8. | Exposure variations/treatment deviations were less than 20%  |
| 9. | Variations in exposure or withdrawals after start of the study were addressed by the analysis  |
| 10. | Procedures for data collection of covariates were reliable and the same for all participants |
| 13. | Outcome assessor(s) were blinded  |
| 14. | Participants were blinded |
| 15. | Caregivers were blinded |
| 16. | Analyst(s) were blinded  |
| 17. | Care was delivered equally to all participants  |
| 18. | Cointerventions that could impact the outcome were comparable between groups or avoided  |
| 20. | Exposure/intervention definition was consistently applied to all participants |
| 22. | The time period between exposure and outcome was similar across patients and between groups or the analyses adjusted for different lengths of follow-up of patients |
| 24. | Key confounders addressed through design or analysis were not common effects of exposure and outcome  |
| 25. | Key baseline characteristics/prognostic indicators for the study were comparable across groups |
| 26. | Participants were randomly allocated to groups with an adequate randomisation process  |
| 27. | Allocation procedure was adequately concealed |
| 28. | Conflict of interests were declared and absent  |
| 29. | Analytic method was justified by study design or data requirements |
| 30. | Computation errors or contradictions were absent |
| 31. | There was no discernible data dredging or selective reporting of the outcomes |
| 33. | Carry-over or refractory effects were avoided or considered in the design of the study or were not relevant |
| 34. | The intervention/exposure period was long enough to have influenced the study outcome |
| 35. | Dose of intervention/exposure was sufficient to influence the outcome |