



Table 1.

Characteristics of included studies ( $n=3$ )

Author, year, country	Study objective	Study setting	Participants	Comparison groups	Intervention	Length of follow-up
<i>CNS complementary provider role</i>						
Talley et al. (1990) USA [39]	To determine the effect of add-on psychiatric liaison CNS consultation on nursing care and the use of sitters.	A large north eastern urban university hospital in the USA where a psychiatric liaison team had been established for >14 years.	107 acute care patients who had been assigned lay sitters primarily because of a danger of "harm to self" or "generally unpredictable" behaviour.  39% aged 20-59 yrs; 36% aged 60-79 yrs; 25% aged >80 yrs; 60% male; 77% white; 41% no prior psychiatric history.	Complementary role intervention (n=47; 11 suicidal, 36 non-suicidal): 2 psychiatric liaison CNSs provided consultations to patients, nursing staff and sitters.  Control (n=60; 11 suicidal, 49 non-suicidal): No intervention.	CNS provided individualized consultations sometimes on multiple occasions  Responsibilities included investigating sitter request, assessment of patient and intervention. CNS interventions targeted nursing staff, patients and sitters.	Hospital stays ranged from 9.7 days (suicidal control group) to 25.33 days (non-suicidal control group).
<i>NP alternative provider role</i>						
Mitchell-DiCenso et al. (1996) CA [40]	To compare NP and pediatric resident teams in the delivery of neonatal intensive care.	Neonatal intensive care unit (33 bed tertiary level unit) in the McMaster Division of Chedoke-McMaster Hospitals, Hamilton, Ontario, Canada.	821 neonates admitted to the neonatal intensive care unit.  58.3% male; 66.1% had birth weight $\geq 2000$ g; mean gestational age was 35.1 wks.	Alternative role intervention (n=414): NP teams (4.5 FTE NPs - all graduates of a 16 month Master's program) provided neonatal intensive care during days (0800 - 1600 hours). Residents provided night coverage (1600 - 0800 hours).  Control (n=407): Residents (n=15) provided around-the-clock neonatal intensive care.	NP team assumed primary responsibility for neonates.  Responsibilities included documenting, infant assessment, identifying medical problems, revising management plans, implementing diagnostic and treatment regimens, and developing discharge plans. NPs wrote medication and medical orders under medical directives.	Follow-up assessment at infant age of 8 months adjusted for prematurity.
Pioro et al. (2001) USA [41]	To compare NPs and house staff in the delivery of care to general medical patients.	General medical care wards in University Hospitals of Cleveland, a 947-bed private non-profit teaching hospital in Ohio, USA.	381 adult general medical patients.  Mean age 47.8 yrs; 39% male; 40% white; 27% had Medicare insurance; 23% had Medicaid insurance; 10% were uninsured; 60% of admissions were for abdominal pain, pneumonia, acute dyspnoea, asthma, fever, gastrointestinal bleeding, CHF, diabetes, infection and leg cellulitis.	Alternative role intervention (n=193): 2.5 FTE NPs and a medical director provided care on weekdays. Off-hour emergency coverage was provided by medical house staff. Note: 90 (47%) were transferred to control wards.*  Control (n=188): Care was provided by house staff.	NPs provided many of the same services delivered by house staff.  Responsibilities included assessments, assembly of patient data, care co-ordination, and implementation of diagnostic and therapeutic plans. Permission to prescribe was not reported.	Follow-up assessment at 6 weeks post-discharge.

\* Transfer of intervention patients to control wards occurred because of attending doctor or NP requests, bed unavailability, chief resident request, or an inability to contact house officer. In some instances, no reason was given for the transfer.