AGREED PROCESS FOR COMMUNITY INTRAVENOUS THERAPY

Date approved

**DOCUMENT PROFILE**

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<td>Administration of Medicines Policy</td>
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CONTENTS:

1. Introduction................................................................. 2
  1.2 Rationale............................................................... 2
  1.3 Outcome............................................................... 2
  1.4 Scope........................................................................... 2
  1.5 Principles............................................................... 2-3
  1.6 Training....................................................................... 3
2. Policy / Purpose............................................................... 3
3. Procedure......................................................................... 3
  3.1 Referrals........................................................................ 3
  3.2 Considerations............................................................ 4
  3.3 Supplies / Consumables for IV administration............... 4
  3.4 Responsibility of administration........................................ 4-5
  3.5 Checks prior to administration.......................................... 5
  3.6 Preparation of medicines................................................ 5-6
  3.7 Care and management of Venous Access devices.............. 6
  3.8 Referral Process........................................................ 6-7
  3.9 Documentation.......................................................... 7
  3.10 Role of Rapid Response Team......................................... 7
  3.11 Role of District Nursing Team......................................... 7-8
  3.12 GP Responsibility...................................................... 8
4. First Dose IV in the community........................................... 8
  4.1 Exclusions................................................................... 8
5. Consultation Schedule....................................................... 9
6. References......................................................................... 9-10
7. Glossary of Terms.......................................................... 10-11
8. Implementation Schedule.................................................. 11
9. Appendices....................................................................... 12
  9.1 Appendix 1 – Troubleshooting......................................... 12
1. Introduction
The purpose of this document is to enable collaborative working with HSSD and FNHC with an agreed process for the effective delivery of Community based IV Therapy. The service will promote quality of life and reduce the necessity for prolonged hospital admission and the complete avoidance of hospital admission in some cases by facilitating and extending care provision at home.

This document is designed to provide information regarding intravenous therapy to any practitioner who has undertaken the appropriate training and has been assessed as competent by a delegated assessor. This in turn will provide an effective Community based Intravenous (IV) therapy service that will promote quality of life, and reduce the necessity for prolonged hospital admission, by facilitating continuing and extended care provision at home allowing earlier discharge and complete hospital admission avoidance. The aim of the document is to provide the evidence and pathway for safe IV therapy in the community setting. It will not cover different access devices, cannulation or actual administration of medications it will cover the processes needed to ensure safe practice and will be supported by SOPs, guidelines and protocols for the technical skills required.

FNHC and Jersey General Hospital are committed to providing high quality care for patients who require the administration of Intravenous Therapy (IV) for specific conditions in a community setting by:

- Staff adhering to the guidelines and protocols
- Maintaining professional development
- Working within the Nursing and Midwifery Councils Code of Conduct
- Working in collaboration with the whole of the Health Economy
- Following Evidence based pathways for the safe and effective delivery of care.

1.2 Rationale
- To enable patients to safely receive IV therapy in their own home, Out of Hospital environments and Nursing or Residential Care homes
- To ensure the safe and consistent practice in the Administration of IV therapy by all Registered Nurses who have undertaken the necessary training and have been assessed as competent by another competent practitioner.
- To provide a sound knowledge base to guide clinical practice based on the best available evidence.

1.3 Outcome
- The patients will successfully complete their treatment without incident.
- The patient will not develop any further complications.
- The patient will not be unnecessarily readmitted to hospital

1.4 Scope
This document extends to all registered nurses required to administer Intravenous therapy in the community setting. It is a requirement that those employed by FNHC attend the required training and have been assessed as having the necessary skills and
competencies to administer IV therapy within community settings. Registered nurses who are employed as permanent or bank staff who have undertaken any other relevant courses within other Health Organisations may also be able to undertake this procedure. The Nurse needs to show evidence both practically and theoretically to the clinical champion within the RRT and/or Adult Community Nursing Team and copies of any certificates will be forwarded to the Education and Training Department.

**1.5 Principles**
Outpatient I.V. antibiotic therapy is a safe well developed service in other jurisdictions. A home-based I.V. antibiotic programme in Jersey has evolved from a desire to provide high-quality I.V. therapy to patients with a number of infections that can safely and effectively be implemented at home. Essential components to the programme include collaborative working between the hospital and community and a written shared care protocol. Such a programme can result in reduced admissions, reduced length of hospital stay and patient, community nurse and physician satisfaction.

**1.6 Training and other Requirements**
- IV therapy may only be administered by registered Nurses that have the necessary knowledge and skills in preparation, administration and monitoring of IV therapies and who feel competent and confident in this practice (RCN 2010).
- All Registered Nurses who undertake this practice must also meet the requirements for use of the Adrenaline Patient Group Direction (PGD) and be signed up to the most recent version of this document. The training requirements include Basic Life Support and Anaphylaxis training and three yearly PGD training. Adrenaline must be carried by all registered nurses who administer medicines including IV therapy.
- Registered Nurses involved in any aspect of IV therapy have a duty to acquire and maintain the necessary theoretical and practical skills required to undertake this role (RCN 2010). Training and education is provided to all community staff within the organisation by experienced practitioners.
- It is the responsibility of registered practitioners involved to maintain and update their knowledge and skills and to keep their own record of professional development.
- All training undertaken for the administration of IV medication must be recorded by the Education and Development Department.

**2 Referrals**
Patients who have been referred for Acute Community IV therapy (72 hours or less) need to have a thorough assessment undertaken to assess their suitability for discharge, the Rapid Response Team (RRT) will provide this assessment prior to any patients being discharged for home IV therapy. For IV therapy longer than 72 hours duration referrals need to be directed to the District Nursing Team which can be facilitated with the RRT. All relevant criteria need to be met before the patient will be accepted.

**2.1 Considerations**
- Where IV therapy is requested there must be a reliable diagnosis and it should be clearly indicated that the requirement for IV therapy is recommended rather than the oral route. In the case of anti-microbial medications these should be changed.
to oral therapy at the earliest opportunity. There must be a completion date or a review date on the initial referral documentation.

- Intravenous anti-microbial therapy via a peripheral cannula should not normally exceed 2 weeks duration. If treatment is expected to last longer than 2 weeks a more suitable access device needs to be considered.

- Commonly accepted conditions for IV therapy in the community include: Soft tissue and skin infections, osteomyelitis, bronchiectasis, urinary tract infections, chest infections, joint infections, diabetic foot ulcers, other conditions will be accepted following risk assessment of both the medication and the condition. Evidence based care pathways will be developed to guide all practitioners.

- The patient must be able to comply with the treatment regime, for example, time off work to rest, elevation of the limb if necessary and understand the implications of the treatment. They must also be available at the recommended dosing times so that doses are not missed inappropriately. Doses that are missed should be documented and action taken to prevent this from re-occurring. Incident forms should be completed if there is no valid reason for a patient missing a dose of their therapy.

3 Supplies of Intravenous Therapy

For patients who are discharged from hospital all drugs, diluents, flushes and any infusion fluids must be supplied for the entire course. If therapy is anticipated to discontinue after 48 – 72 hours with a view to step down to oral therapy, the oral medications must be supplied with the intravenous medication to avoid missed doses and delay in treatment. All other consumables should be provided by Jersey General Hospital for the duration of the treatment. For RRT, consumables will be utilised from ED and the RRT will be required to complete the stock list used each time consumables are taken.

If the duration of treatment alters in any way i.e. if patients need to continue for any extra time then the Doctor with medical responsibility for the patient is to provide further medication. If the patient stops treatment before prescribed medication is used up it is the patient’s responsibility to arrange for the disposal of any remaining medication by returning it to a community pharmacist. Community nurses do not generally arrange disposal of patient’s own medicine as the prescribed drugs belong to the patient.

3.4 Responsibility for Administration

The Nurse who is administering the IV therapy has a responsibility to ensure that they have the necessary knowledge and understanding of the medicine that has to be administered, including:

- Indication for use
• Recommended dose and frequency
• Methods of preparation
• Rates of administration
• Any special monitoring or health and safety requirements
• Contraindications
• Side effects and potential adverse reactions and the appropriate intervention particularly related to the management of anaphylaxis

The Nurse administering the medicines must be completely satisfied with the prescription, ensuring that it is clear, unambiguous and appropriate for the patient’s age and condition. If the nurse has any queries at this point he/she should contact a pharmacist or the medical prescriber who completed the prescription to query it.

**3.5 Prior to administration the nurse should check:**

• The patients name and address
• The date the treatment is to commence and review/completion date
• The correct medicine name, form strength
• The dose to be given
• The route of administration
• The time and date of administration
• The expiry date of the medicine, diluents, flushes and infusion fluid (where applicable)
• The method of administration
• Any known allergies / previous reactions

The nurse should delay and seek immediate advice if there are any doubts or concerns regarding either the patients’ prescription or their condition. If at any time during or following treatment, the patient’s condition has not responded or become worse, the nurse must arrange a medical / senior review.

**3.6 Preparation of medicine**

• The Nurse or practitioner administering the medications and solutions shall have knowledge of the indications for therapy, side effects and potential adverse reaction, and appropriate interventions (Nicol, 1999) particularly related to the
management of anaphylaxis (information leaflets as per manufacturers information and instructions may be supplied with the medication).

- Prior to administering medications and solutions, the nurse shall identify the patient; verify the contents, dose, rate, route, expiration date and integrity of the solution (Shulman 1998, Nicol 1999, Dougherty 2000, NMC 2004, NMC 2007).

- The nurse shall be responsible for the evaluating and monitoring the effectiveness of the prescribed therapy, documenting the patient's response, adverse events, and interventions and achieving effective delivery of the prescribed therapy (NMC, 2007)

- Advanced preparation of substances before their prescribed time is not acceptable unless supplied in a pre-prepared state directly from pharmacy.

- The medication must be prepared aseptically immediately prior to administration in accordance with the manufacturers instructions for reconstitution.

- For further information please refer FNHC medication advice sheets and to the manufacturer’s information –the Summary of Product Characteristics (SPC) and the British National Formulary.

- The registered Nurse must carefully examine all medicines and fluid containers ensuring that they are patient specific and appear free from particles, contamination and faults and that they are in date.

- The Registered Nurse shall report any adverse effects via the yellow card system to the MCA.

3.7 Care and Management of Venous Access Devices

3.8 Referral Process of patients to the Community IV Therapy Team.
- A clear diagnosis needs to be made and confirmed prior to a referral being made.

- The hospital team should ascertain the correct medication for each patient.

- The hospital pharmacy should confirm the correct dose and method of administration before the patient is discharged.

- Referrals for IV therapy longer than 72 hours duration need to be referred to the District Nurses. For 72 hours or less referrals need to be made direct to the Rapid
Response Team who will provide an assessment of suitability whilst patient remains in hospital based on the criteria and home circumstances. Referral forms (if appropriate) and the medication administration form should be fully completed before discharge.

- Patients should have the appropriate Vascular Access Device in place before discharge.

- Verbal consent to treatment in the community should be obtained by the hospital prior to discharge and a full explanation of what it means to the patient to have community IV Therapy.

3.9 Documentation
Record keeping is carried out in accordance within the NMC record keeping and organizational policy / guidelines, and will include all the relevant documentation specific to IV administration and VAD monitoring i.e. VIP phlebitis score, PVAD care bundles.

3.10 Role of Rapid Response Team (RRT)
The role of the team is to facilitate, and initiate where appropriate, home intravenous administration of antibiotics for those patients requiring short term not more than 72 hrs for acute conditions. The team reserves the right to take advice from the HSSD microbiologists and Infectious Diseases Consultants over any patient referred to them. Patients who require routine antibiotics or other IV therapy will be referred on at the discretion of the rapid response team. The RRT will respond to referral within 2 hours. A thorough clinical assessment will determine if the patient is deemed suitable for therapy under the care of RRT and / or DN service. The RRT decision will be final and based on the clinical needs and safety of the patient. If the patient is deemed unfit / unsuitable alternative provision will be discussed and appropriate re assessment if indicated will be arranged.

3.11 Adult Community Nurse Service responsibility
- To give complete care to the patient receiving IV Therapy
- To ensure that the IV Therapy is administered safely and effectively.
- To alert medical staff to any reaction to the treatment that the patient may suffer and to report any events as per organizational policy.
- To liaise with the Medical team with responsibility for the patient with regards to any changes in treatment or any further blood tests that may be required.
- To alert the patients Consultant of any significant event.
- To maintain accurate records and monitor vital signs on each visit and record appropriately.
- To attend mandatory updates for IV therapy whenever they are due.
- To act within the NMC code at all times.

3.12 GP Responsibility
When identifying a patient that would be suitable for IV Therapy in the Community the Community nurse will discuss with the GP and ensure that

- The team has capacity to accept the patient and discuss alternatives with the GP if capacity issues.
- The GP has completed all of the necessary documentation required by the team for the patient including confirmation that the treatment has been discussed and agreed with the Consultant Microbiologist.
- The GP has completed the Health Insurance Prescription ensuring that all necessary medications, diluents, flush and infusion fluid is included. (See appendix)
- The prescription should either be given to the patient to take to the pharmacy or faxed if appropriate to enable the pharmacist to prepare the medication. The pharmacy will receive / collect the original copy of the prescription before the medication is given to the patient.
- The GP has provided all the information including any blood monitoring required and that this if is documented on the referral

4. First Dose of IV therapy in the community setting

Traditionally, nurses have not been authorised to administer the first dose of an antibiotic because of concerns that the patient may experience an anaphylactic reaction. Problems with anaphylaxis tend to occur with the second or subsequent doses of an antibiotic (UCL, 2010). By authorising appropriately trained nurses to administer the first dose of intravenous therapy in a community setting, patients will get prompt treatment. Patients may experience an adverse reaction to the first or subsequent doses of any drug and the nurse must be able to respond and act when someone has anaphylaxis. Nurses will be up to date with basic life support and anaphylaxis training. First doses can be administered in the community setting as long as the nurses:

- Are working within their scope of practice
- Have the appropriate knowledge and skills to deal with anaphylaxis
- Are competent to administer IV therapies
- Follow NMC guidelines on the administration of medicines
- Have access to adrenaline and a telephone

No intravenous antibiotic should be administered unless the allergy status of the patient has been documented in the patient’s case notes. The allergy status of the patient must be checked verbally with the patient before administration of the first dose of an antibiotic.

4.1 Exclusions

If a patient has experienced any of the following they must have their first 2 doses in a hospital environment with medical supervision and monitoring:

- Previous anaphylaxis
- On medical advice
5. Consultation Schedule

<table>
<thead>
<tr>
<th>Name and Title of Individual</th>
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<tr>
<td>Dr Ivan Muscat</td>
<td>December 2013</td>
</tr>
<tr>
<td>Barbara Bell</td>
<td>December 2013</td>
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<tr>
<td>Cally Lewis</td>
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<tr>
<td>Gary Kynman</td>
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<td>Infection control JGH / FNHC</td>
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6. REFERENCE DOCUMENTS


7. **GLOSSARY OF TERMS**

**A community** - refers to a community setting which includes: patients own home, residential care, nursing home, community health centre and intermediate care setting.

**Intravenous (IV)** - refers to therapy that is administered directly into the vein.

**Cannula** - refers to the short peripheral device through which IV therapy can be given directly into the vein. Cannulae are made from a variety of materials and vary in gauge and length. They are ported or non-ported.

**CVAD** - refers to any intravenous catheter whose tip lies in a large central vein, giving what is termed, central access.

**Anti microbial therapy** - a medicine that is designed to treat various forms of bacterial, fungal or viral infections.

**Prescription** - a written direction authorised by an appropriate prescriber which authorises a supply of medication for a patient. “Prescription” in this context of this policy refers to e.g. the FP10 form that a GP writes, or to the internal hospital prescription that the patients “Take Home medication” is prescribed on.

**Peripheral Venous Access Device (PVAD)** - refers to any device that may be used to deliver IV therapy into the peripheral circulation of a patient.

**Midline catheter** - This is a device that provides vascular access into a larger peripheral vein. They can be placed in the home and do not require an x-ray to check tip position. They should be cared for in the same way as a CVAD. They can be used for short to medium term therapy.

**Peripherally Inserted Central Catheter** - Is a device that can be inserted into a large peripheral vein. The tip of the lines position needs to be checked by X-ray the tip sits in the Superior Vena Cava (SVC). These devices are used for longer term therapy.

**Patient Group Direction (PGD)** - A written instruction for the supply and / or administration of a licensed medicine in an identified clinical situation, signed by a doctor or dentist and a pharmacist. It applies to groups of patients who may not be individually identified before presenting for treatment.
**Skin-tunnelled Catheter** - Another type of CVAD that has a skin tunnel, which makes the line more secure and forms a barrier to reduce the risk of infection.

**Temperature, Pulse, Blood pressure (TPR)** - these are recordings of the patients vital signs that may form a baseline observation that will allow the nurse to monitor the patients condition.

8. IMPLEMENTATION PLAN

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<th>Action</th>
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<tbody>
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<td>Communicate policy update and associated IV documentation to all FNHC staff and HSSD</td>
<td>Tia Hall / Clare Stewart</td>
<td>Gary Kynman</td>
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<tr>
<td>Upload onto FNHC and HSSD intranet</td>
<td>IT Department FNHC and HSSD</td>
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<tr>
<td>Training for FNHC staff</td>
<td>Tia Hall / Clare Stewart</td>
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### 9 APPENDICES

**Appendix 1**
Hazards Associated with Administration of Intravenous Therapy

<table>
<thead>
<tr>
<th>4.1 Administration via venous access device and planned action Risk</th>
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<td>Suspected anaphylaxis</td>
<td>Emergency procedure as per organisational policy</td>
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<td>Deterioration of patient’s condition.</td>
<td>Discuss with consultant team responsible for treatment of Current medical conditions, to which intravenous therapy have been prescribed and consider re-admission.</td>
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<tr>
<td>Inability to Flush VAD</td>
<td>Observe for kinking of cannula. Refer to troubleshooting guide “Intravenous access care and maintenance”. Consider Removal and re-siting of peripheral line</td>
</tr>
<tr>
<td>Inability to re-site VAD after 3 attempts</td>
<td>Contact AED to arrange for recannulation</td>
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<tr>
<td>Suspected extravasations</td>
<td>Remove cannula, apply cold pack to cause vasoconstriction, Consult medical practitioner, who will consider administration Of Dexamethasone 4mg – 8mg subcutaneously around site. Elevate limb and apply hydrocortisone cream to reduce Localised inflammation (twice daily).</td>
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<tr>
<td>Suspected infection of VAD</td>
<td>Refer to Visual Inspection Phlebitis score Peripheral cannula remove and re-site. For Midline, PICC, Skin Tunnelled catheter, seek medical advice from Consultant/ Specialist Nurse immediately, considers re-admission</td>
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<tr>
<td>Infection within VAD (sepsis)</td>
<td>Inform consultant immediately to arrange urgent re-admission.</td>
</tr>
<tr>
<td>Withdrawal occlusion</td>
<td>Check line is not kinked, or sides stuck together. Check flow Switch not broken, ask patient to raise arm and lie on one side. Refer to troubleshooting guide ”Intravenous access care and Maintenance”. Consult medical practitioner for advice and</td>
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All suspected adverse reaction effects shall be documented and copied to Patient’s notes, Operational Lead and Consultant Microbiologist, consultant physician.
Appendix 2

### PVAD Care Bundle - Adult

#### Part 1: For In-Patient Use Only

- **PVAD Sites**: Left, Right, Hand, Foot, Other
- **PVAD Insertion - Safety**: Yes, No

#### Part 2: Observations of PVAD - Daily Checks

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#### V.I.P. Score (Vascular Infusion Phlebitis Score)

- **0**: No signs of phlebitis
  - **1**: Observe cannula
- **2**: Early signs of phlebitis
  - **3**: Resite cannula
- **4**: Advanced signs of phlebitis
  - **5**: Initiate treatment, resite cannula

#### Part 3: PVAD Removal

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© NHS SJ, IL 08 14
Adapted from the North West London Hospital
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