Restraints Minimisation Policy

Restraints Policy and Guidelines

**RESTRAINTS POLICY:** The standard aims reduce the use of restraint and to ensure that it is used safely. Some restraints are requested voluntarily as they enable the person to either feel safer or to provide physical support [postural]. Our policy focuses upon reducing and managing challenging behaviours rather than to restrain.

**REFERENCES:**
- The Code of Health and Disability Services Consumers' Rights
- Informed Consent & Advanced Directives Policy
- Privacy Act 1993 / Policy Privacy & Dignity
- Interpreter Policy

**Definitions of Restraint**

- **Restraint** is the implementation of any forcible control by a staff member that:
- Limits the actions of a resident in circumstances where the resident is at risk of injuring himself or herself or another person. It intentionally removes their normal right to freedom / or prevents normal access to parts of their own body.

**Restraints can be:**

- **Personal** - such as being physically held
- **Physical** - such as the use of furniture or equipment e.g. geri tables & cot sides
- **Enablers** - where the resident voluntarily uses equipment to assist them to maintain independence such as a chest harness in a wheelchair, which supports posture and prevents the person slumping forwards.

**Chemical Restraint**

This is the use of medication to render a person **incapable of resistance.** Such medication is not prescribed by the home; rather, prescriptions are limited to those with valid indicators.

- **Environmental** - where the resident is put in an environment that reduces their level of social contact and/or environmental stimulation. E.g. Alzheimer’s Unit.
- **Seclusion** - placing a person at any time and for any duration alone in an area where he or she cannot exit freely. E.g. locking someone in their room.

Chemical restraint and seclusion are not supported by the policy of this Home in any way. A Log of restraint usage is kept - if no restraints the log is empty.
The policy of the Home is not to restrain anyone.

Environmental – the Home is a special unit for people who need a special environment.

Bucket chairs may be used for very frail people – they are seen as enablers as they allow the person to be in communal areas, participating socially, rather than in their beds.

Cot sides are used because the resident requests them and does not feel safe without them.

Harness or other enabler gives the client more independence but its use restricts normal access to part of their own body so it is a restraint.

The Team

The Team consists of the Manager or their delegate, Team Leader or RN, members of the Health & Safety Committee and other staff, as appropriate. Each six - 12 months they agree and review:

- All restraint policy & procedure [doctors may be invited to endorse the policy]
- The content and competencies of the Home Education Package annually.
- Incidences of Challenging Behaviour.

For incidences of challenging behaviour, key members from the team will:

- Assess all information available
- Discuss all means of prevention
- Assess adequacy of staff training and education
- Listen to family who may provide valuable information resource
- Have team review meetings to decide care guidelines.
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**Training**

All staff must receive this training PRIOR to being involved in any care requiring restraint! A record of this training is kept. Competency is tested annually.

- Definition of Restraint / our policy & procedures
- Types of restraint
- Legal aspects of restraining
- Resident safety & risk assessment
- Challenging Behaviour & communication techniques
- Aversion versus non aversion techniques - ethical issues
- Alternatives to restraint use
- De-escalation techniques
- Comprehensive assessment - description, history, antecedents, consequences.
- Rights of family/whanau & family involvement
- Record keeping
- Physical, psychological & cultural risk
- Increased need for dignity privacy & cultural safety

Staff need to be trained at induction and to have refreshers when incidences of Challenging Behaviour arise or at least annually. Competency is assessed as part of training, and through incident reporting. **Personal restraint** is not endorsed by the Home, so rather than teaching holding techniques, we teach de-escalation and struggle avoidance. Staff are trained to move people to a place of safety and call for help where faced with violence.

**Before ANY restraint can be used it must be approved.**

**Approval Process**

The Team Leader is responsible for leading the Restraint Approval Group and maintaining the approved standard. The Approval Group consists of the Manager, Team leader, a resident advocate, or a GP, or komatua, decided as appropriate, according to individual client need, including suitably qualified person.

.................................................. [state who] fills the Restraint Co-ordinator role.
ASSESSMENT: Based on resident physical & psychological health

In considering restraint use, all other alternative must be considered first.

For each form of restraint, key members from the approval group will look at:

- Discuss present care.
- Evaluate the problems from challenging behaviour reports - calling on outside consultant at Manager discretion.
  - Include contradictions to the use of restraint, e.g. cultural
  - Underlying causes [that can be rectified]
  - Existing Advanced Directives
  - Previous restraint episodes [whether successful]
  - past history of abuse where person held against their will
  - grounds for needing the restraint [e.g. safety of others]
- Look at all possible alternatives to restraint.
- Assess adequacy of staff training and education.
- Hear family perspective for greater understanding.
- Seek greater understanding of the service user/ resident.
- Consider the risk of any restraint versus non restraint.
- Decide frequency of monitoring, observation and evaluation requirements.
- Decide when it might be used.
- Elect person responsible for initial assessment - and set date
- Review by as many people in the group as possible - and set date.

NB: The policy of the Home is NOT to restrain, so in the event that someone is unable to be harmoniously managed, it is likely that a greater level of care might be required for that person.

Discontinuation of Restraint:

- No longer needed
- It is causing undue distress
- Risk to the person restrained is GREATER than the risk of not restraining
- The restraint is compromising professional relationships with staff.
Any restraint in use needs to have back up information for staff, in the event of difficulty, staff need to know who to call and that assistance is available.

Challenging Behaviour management needs clear documentation in Care Planning so that staff are guided in their care. The Team Leader is responsible for gathering staff together and discussing / explaining the methods of care that best prevents the challenging behaviour from arising, or if it does arise - how to best manage it. If everyone shares the same approach we may succeed better. Some staff will need more support than others - this is evidenced by challenging behaviours only happening on one shift or when certain people are on duty. Staff with an authoritarian approach may find that this inspires resistance and may need to realise that it is their behaviour, not that of the resident, that needs to change. Where there is a problem with challenging resident behaviour it is a good idea to ask which staff member does NOT have a problem with this person - then ask how they care for / deal with this person. However, should restraint approval be granted, the Team Leader, Medical Practitioner and the resident [or their welfare guardian/advocate/family must sign a consent. Restraint cannot be used without family knowledge / approval.

**APPROVAL PROCESS**

Restraining someone is a LAST RESORT when nothing else works.
It is a decision made by an appropriate Health Professional
Restraint is only possible in correct environment & with adequate resources.

First Consider:
What are the possible alternatives?
We prefer the least restrictive way to solve the problem?
We look at **Risk** with and **Risk** without restraint [use form below]
Risk includes people Rights & Feelings
We look at the risk of infringing on cultural grounds

The Home prefers NOT to restrain. If someone needs restraining we will look at having the person assessed to go to a place of greater care.
### Risk Assessment Form

To be used by the Restraints Group PRIOR to deciding ANY restraint usage.

Please score in box to give Assessed Risk e.g. A1 Life threatening and likely, or C3 Minor and unlikely (remote possibility).

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<th>HARM</th>
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<td>A life threatening</td>
<td>1 likely</td>
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<td>B serious injury</td>
<td>2 possible</td>
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<tr>
<td>C minor injury</td>
<td>3 unlikely</td>
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Risk may be minimised by:
- Applying pads to limbs
- Soft pillows
- Lowering height beds/chairs
- Providing entertainment (books or music)
- Regular supervision
- Other resident company
- Ameliorating cultural risk etc.

As many members of the Restraint Group as possible should contribute to the risk assessment.

**Designation / Role**

[Family, doctor, RN, caregiver, etc.]

Sign: ____________________________

Sign: ____________________________

Sign: ____________________________

Sign: ____________________________

Sign: ____________________________

Review by: ______________________ [date]

Review co-ordinator: __________________ [name]
Consent Form for Use of Restraint

Name of Resident:                           Date:

Type of restraint:

Reason for restraint use:

☐ Bed rails - falls out of bed / requests them and feels safer with them
☐ Bucket chair [an enabler that allows greater participation in the social program]
☐ Harness [enabler that assists to sit upright in a chair rather than falling forward].
☐ Other:

I feel that I fully understand and support the decision to restrain__________________________ Resident

☐ I consent to the recommended restraint being used under the conditions specified in Care Planning.

☐ I feel that I understand the risks of NOT restraining compared to the risks of restraining __________________________ and have decided NOT to restrain is the best option.

Resident

To be completed by the resident/ resident’s welfare guardian / family advocate.

NB: The risk of falling, or other injury, may be preferred to the risk associated with restraint.

Signature:_________________________  Date: ____________________

Print Name: _______________________

Additional Comment / Monitoring Requirement:

RN / Manager’s signature:_______________  Date: _____________

Team Member signature:_______________  Date: _____________

Doctor’s signature:_______________  Date: _____________
Assessment

Assessments by staff, as discussed earlier, are more robust where outside experts are part of the process. The decision to restrain someone should not be taken lightly nor be the decision of one person alone. We need to look upon this person as we would our own parent and consider their feelings:

- Are we providing care where they feel comfortable and safe?
- What are realistic goals?
- Why there is a problem and what happens to cause it?
- How the resident / service user feels about this.
- Are their any early signs that warn us so we can PREVENT the problem?
- Does the resident feel safe? Are they safe?
- Are they making others less safe?
- What LEAST restrictive restraint is being considered?
- How might that affect the resident / service user and their family?
- Have the family been part of the risk assessment & planning process.
- If we do use a restraint what things will make it safer - e.g pillows under legs of frail person in bucket chair, protective stockings.
- Specific cultural needs and how these would be best met

Cultural Recognition

When considering the need for restraint needs of all cultural groups must be taken into account. The resident / service user and their family [whanau] must be consulted with regard to the resident’s value / belief system to minimise the risk of cultural infringement during the use of restraint. Where the resident and their family are part of the planning process this is a learning curve for everyone and counselling is part of this process. External cultural advice may need to be sought to ensure that cultural safety is ensured. If the need arises for any objects of significance to be removed [where resident safety is compromised] this is done appropriately and safely. Cultural needs of residents’ must be known and met during restraint use. This generalises to all cultures.
Risk Management

Use the Risk Management Form to guide assessment of risk. Compare the risk of harm to the service user / resident with restraint to the risk of harm without it. Consider both the DEGREE of risk and the LIKELIHOOD.

Dignity and Privacy

Resident privacy & dignity is considered and protected at all times – e.g. if a frail person is in a bucket chair they will be taken to their room to be turned or cleaned – not in the communal area.

Consent & Client Participation

Where the resident / service user cannot fully understand the reasons for restraint [including enablers] then consent is sought from family. It is always preferred that the resident themselves are part of the restraint Group and are considered the key stake holder.

Consumer Support and Communication

Residents, their families need to be part of individual reviews. They need to be consulted about any decisions related to their family member’s care - this is specially necessary should personal items need to be removed. Information about any restraint considered must be in a form that the resident / service user or their family / advocate can understand.

Since bucket chairs and enablers are the only restraint likely to be used in the Home debriefing is not usually required. However, should this be needed then appropriate staff or external support would be provided.

Monitoring & Review

Monitoring needs to consider:

Physical Needs:
- health
- nutrition,
- hygiene, comfort & safety
- frequency of care
Psychological Needs:
- support, comfort, privacy & dignity
- orientation to time and place
- communication opportunity

Cultural Needs:
- Access to family & to support networks
- Appropriate support
- Cultural objects valued by the person cared for and protected.

Individual Review:
Clients using harnesses and bucket chairs and cot sides require careful monitoring [see Restraint Monitoring form. Frequency of monitoring is agreed among the restraint group and documented in Care Planning. Review is 3 – 6 monthly or more frequently as decided by the Team. See Individual Restraint Review Form.

Accurate accounts of Restraint Episodes are required. This is according to the frequency & duration of the restraint. This must also include:
- Reassessment of reason for the restraint in the first place
- Reconsider alternatives
- Degree of success the restraint is having [or not]
- Family input & perspective
- Short term outcomes/ long term outcomes
- Peoples observations, particularly the resident perspective
- Assessment of ANY injuries sustained during restraint [may inspire review!]
- Support people available
- General observations
- Consideration of less restrictive form of care.
- Alternatives and other options
- Staff ability to manage the restraint as required.

Frequency of recording should be practical. Sufficient to ensure good communication between shifts, and to record that staff tasks are done regularly enough for resident comfort. We do not like to record unnecessarily.
Quality Review of Restraints:
This is undertaken at least annually. If no one in the Home is restrained focus is generalised towards Managing Challenging Resident Behaviours. The Manager usually calls upon external consultant for support with this review. If service users / residents are restrained then the review may be six monthly. These are the set agenda items:

1. Type volume frequency & duration of restraints in home
2. Compliance with policy. Checklist for each restraint in use:
   - Dignity & Respect
   - Resident Rights
   - Privacy
   - Advocacy (family)
   - Culturally appropriate
   - Recognising special needs
   - Assessment is ongoing
   - Approval processes, policies and procedures
3. Whether alternatives to restraint have been identified as part of the plan of care.
4. Communication effectiveness with family / family participation for each restraint. Those who are restrained OR show challenging behaviours are discussed individually.
5. Support provided to residents and staff involved.
6. The effectiveness of individual restraint evaluation and review.
7. How periods of restraint are monitored and observed.
8. Staff competency and training includes assessing the competence of trainers.
9. The appropriateness and effectiveness of restraint related education.
10. Progress towards a restraint free environment.

Quality review findings and recommendations are used to improve our service and resident safety considering current Best Practice Guidelines. Monthly audits of Challenging Behaviours are inputted in the Benchmarking Stats Program and reviewed by outside consultant at least quarterly and Service Review.
Restraints Minimisation Policy

Restraint Guideline Flowchart

1. PRECIPITATING EVENTS IDENTIFIED
   - Behaviour identified & documented
   - NO
   - CAN WE PREVENT THIS BEHAVIOUR
     - YES
     - Formulate Guidelines
     - Document guidelines in Care Plan
     - All staff know guidelines

2. RESTRAINT GROUP MEET
   - RN
   - GP
   - staff
   - family
   - diversional
   - other

3. DE-ESCALATION TECHNIQUES
   - environmental change
   - toileting / continence
   - activity / enjoyment
   - care management
   - companionship
   - behavioural modification
   - reduction in discomfort
   - more

4. EXPLORE ALTERNATIVE STRATEGIES
5. CONSIDER LEAST RESTRICTIVE RESTRAINT [LEAST TO GREATER]
6. IDENTIFY & DOCUMENT RISK OF RESTRAINT
7. INFORMED CONSENT DOCUMENTED PLAN AGREED MONITORING LOGGED IN REGISTER REVIEW DATE AGREED CO ORDINATOR AGREED

8. RERAINT GROUP MEET REVIEW RESTRAINT [BENEFIT VS DISTRESS]
Restraints Minimisation Policy

Checklist for Restraints Group
[To be used in conjunction with Flow Chart]

Name of Resident__________________________________________ Date______________

Behaviour has been identified and documented [Try and make assessment over 24 hour period, more than one assessor, more than a snapshot in time – look for the bigger picture].

Behaviour is seen by staff as challenging [A social or a safety challenge]

Restraint Group meets – always include significant family / whānau / where possible at initial planning stage.

Precipitating events have been identified

Can we prevent this behaviour?

Incorporate preventative measures in care planning and inform all staff [Look to increase resident perception of their own safety / reduction in resident perceived discomfort]

List de-escalation techniques in care planning and inform all staff

Alternative strategies to restraint usage explored first

Consider least restrictive form of restraint. [Some residents may request some forms of restraints e.g. enablers, bedrails, special bucket chairs].

Consider the risk – identify and document.

Log initiation of restraint in Home Restraint Register

Nominate person to coordinate THIS restraint’s use

Nominate date for first review [Review should include as many members of the Restraint Group as possible / sensible.

Use this checklist as a guideline only.

Do not feel that you need to move down the list – the goal is to AVOID the use of restraints, if at all possible. The less boxes checked, the better.

The true challenge is avoidance of the need for restraint while still keeping all residents and care givers safe.
Restraint Monitoring Form

Resident Name: ___________________________  Date: ________________

Type of restraint agreed by group: _______________________________________

Maximum time that restraint may remain in use is:___________________________

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<td>Persons present:</td>
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<td>Is there adequate documentation of monitoring? Yes ☐ No ☐ State:</td>
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<td>Does the Care Plan reflect the Restraint in its present form? Yes ☐ No ☐ State any updates needed.</td>
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Note - changes need update to consents as well.

Review completed by:

Signed ____________________ Doctor _______________
Signed ____________________ Residents Family or Advocate _______________
Signed ____________________ Manager or RN _______________

Date of next Review:
## Assessment of Challenging Behaviour

To be used by all Care Staff concerned by resident action or behaviour

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1. Were there any early warning signs?

2. What did the behaviour look like [Who did what when]?

3. How long did it last / did anything make it worse?

4. What got damaged (if anything)

5. Who got hurt (if anyone) & describe injury [or damage]

6. CLIENT PERSPECTIVE: What happened before the behaviour started?

7. Contributing factors: (family, medical, environment, social, care given)

8. What lead to the behaviour [including nothing going on i.e. boredom]

9. What we did to prevent this happening again:

Please write on the back if you need more space. Write N/A [not applicable] in boxes not required.
Challenging Behaviour Review Form

Use to document staff review of Challenging Behaviour.

First signs of problem

Describe

What makes it worse?

E.g. ignored, growled at.

Describe the challenging Behaviour

E.g. bored, nothing to do, no visitors, substance use recently

WHY – What is causing this behaviour

SOLUTIONS

1. Stop [yes I know you are probably rather busy]
2. One person recognise this person [face to face / by name / friendly / at their eye level]
3. ....
Assessment of Knowledge Restraints

What is a “restraint?”

Please name two kinds of restraint.

Do you think that it’s OK to restrain people?  
YES  NO

Would you physically hold onto an old person to stop them from walking away from you?  
YES  NO

Would you physically hold onto an old person to stop them from walking out on the road and getting hit by a truck?  
YES  NO

What kind of restraint is that? Please tick the correct answer.

- Chemical
- Physical
- Personal
- Environmental
- An enabler

Please tick the boxes below if you know residents who have had the kinds of restraint listed below:

- Lap boards and Geri tables
- Bed rails
- Bucket chair
- Lap belt or wheel chair belt to tie them in
- Harness to hold someone upright in a chair

What do you think? Did they really need this restraint?  YES  NO

What could we have used instead?

Sign............................................ Designation..........  Date...............
Training Signing Sheet

Topic: Restraints

Trainer: ______________

Date: __________

PLEASE PRINT CLEARLY
We have discussed Restraints. I have been shown and understand what was demonstrated. Anything that I did not understand, I asked for and received adequate explanation.

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