Step by Step Process: How to complete a TOP5

Step One: Information

Carer and patient are given a brochure that explains TOP5.

Step Two: Completion

A member of staff asks the carer for their tips in how to communicate with, care for and engage the patient. Every TOP5 needs to be written with consideration to the:

- **Action** (what staff need to do or not do)
- **Reason** (why this action is important to the patient)
- **Consequence** (what is likely to happen or not happen because of this action)

The TOP5 form must be completed by the staff member (not the carer).
It is a medical record and while the carer is the expert about the patient's personal needs, the staff member understands the clinical environment and how to record information that will be relevant to clinical handover.

The staff member who begins the TOP5 does not need to complete 5 tips with the carer in one go. The carer may not be able to think of 5 tips at one time. Also, other members of the team may find out additional information from their engagement with the carer and can add to the TOP5 later.

Step Three: Identification

The TOP5 form is put on the bedchart as close to the front of the bedchart as possible.

A rectangular sticker may be put on the spine of the patient's notes and in the progress notes where the interaction with the carer is documented.

Step Four: Transfer of care

When the patient is leaving hospital the TOP5 can be photocopied and given to the carer to take with them. The original stays in the Medical Record.

If you need resources for TOP5 contact the Carer Support Unit on 4320 5556 or email CCLHD-CSUCC@health.nsw.gov.au