

## CASE STUDY 3: RESIDENT PLATE WASTE

### MRS JOAN FAY \*

Mrs Fay is a 78 year old resident. Nurses have observed that Mrs Fay has not been eating all of her meals and has been complaining of a having a poor appetite and feeling full. The nurses report their findings to the care manager who decides to organise a resident plate waste audit of Mrs Fays meals over 3 consecutive days to see how much she is eating.



The care manager informs the staff who will be looking after Mrs Fay's unit for the next 3 days to observe each of her meal times and record her intake on the resident plate waste chart as per instructions on the chart.

Mrs Fay's intake observations are demonstrated on the completed resident plate waste chart attached.

#### **Breakfast**

Mrs Fay was served two slices of toast and a cup of tea. Mrs Fay's plate waste equalled zero.

#### **Lunch**

At lunch time her plate waste was consistently very high as she wasn't eating much of her meal. Mrs Fay complained her appetite was worst at lunch time.

#### **Review**

The care manager reviewed what Mrs Fay was eating at breakfast and decided to increase the serving sizes of her meals. The care manager offered Mrs Fay her a bowl of cereal in addition to her toast and tea to increase her food intake. Mrs Fay was happy with the addition to her breakfast and it meant she was maximising her intake by eating most when she felt hungry.

# SAMPLE

- Resident:** MRS JOAN FAY  
**Medicare No.** 111111111  
**Pension No.** 222222  
**Medical Officer:** DR JONES  
**Diagnosis** Arthritis  
**DOB:** 07/04/1931  
**Veterans No.**

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