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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #17-090-9005
Robert Young Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services with Robert Young Center. The allegations were as follows:

1. Inhumane treatment, including rude and inadequate treatment by staff, information being withheld regarding treatment, and inadequate medication being provided to patient.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4).

The Center provides mental health services for 5 hospitals in Iowa and 2 in Illinois, and both regions act as the catchment area. They are considered a community mental health center but have a collaborative agreement with Trinity Hospital for inpatient services. They provide adult, child and adolescent inpatient mental health services and adult inpatient substance abuse services, with 2 units for each. They have 54 licensed beds in the adult unit with filled beds flexing in number from 17 to 25 and on the children's unit filled beds range between 14 and 6. There are 31 total beds for the mental health populations and 23 for substance abuse. The Center employs 330 staff members.

Complaint Statement

These incidents allegedly occurred over the 9/24 weekend. The complaint alleges that a patient's blood pressure increased because the patient was not receiving her prescribed anxiety medication, which caused blurry vision. A nurse finally entered the patient's room and discovered what was going on. The nurse left, but no one reportedly came in to help the patient. Finally the patient left the room and asked staff why they did not assist her. The person that initially came into the room said that a specific nurse was informed who did not allegedly follow-up on the patient. The patient's mother had to inform staff about the blood pressure problem at one point. As per the complaint, that same nurse who did not assist the patient was rude to the patient and talked to her like a baby. The patient called her mother for help with the

situation. When the patient's mother called back, the nurse reportedly hung up the phone on her twice and then accused the patient's mother of threatening to sue the hospital. The patient's mother never threatened to sue, but did say she would make a complaint. Allegedly, the nurse said that she was tired of the patient's mother calling and making threats. According to the complaint, the nurse said that he did not care who the mother sued and said if her mother would be quiet, he would tell her what occurred. The patient asked the nurse to not be rude to her mother which caused the Charge Nurse to tell the patient to "Watch your blood pressure."

A nurse also reportedly asked the patient once if she was homicidal, suicidal, or just mad at her. On another occasion as nurse rudely asked the patient "Do you want your medicine or not?" as per the complaint. Allegedly the nurses would gossip about the patient and acted like they just wanted to babysit. The patient allegedly said that she did not want a nurse to be her nurse any longer and they said that she had to have the nurse until 11pm. Additionally, the accusations state that the patient's fingers were numb and tingly and staff said that they would inform the physician the next day but nothing was done until a specific nurse looked at the hand and had suggestions on how to lay on it. A previous physician accused the patient of only being at the emergency department to get pain medication and threatened to take away her medication. Later the patient started receiving treatment from a nurse practitioner but the facility hid information that the supervisor of the nurse practitioner was the same physician.

Finally, the complaint states that a patient was given Tylenol even though she told staff that the Tylenol made her stomach upset. Allegedly the patient suffered the entire day without her needed medication. Also the patient was reportedly told that it was $400 to receive her records.

Interview with staff (11/21/2016)

Staff began the interview by stating the physician and nurse practitioner with this patient were from the outpatient unit; the allegations that medication was refused and that they were hiding the fact that the physician was a supervisor are not accurate. They explained that nurse practitioners have a collaborative physician as is required by law. It is not a supervisorial situation. If the case is complicated, the two would probably collaborate but not on every case. The patient was at the facility from the 9/23 until 9/26.

Staff explained that medications are addressed in the H & P [History and Physical Examination] and the patient was to have a Benzodiazepine three times a day PRN [As Needed]. The patient was to remain on high blood pressure medications and her blood pressure was high during the stay. She presented at the emergency department for a drug overdose and had just been discharged from another facility. She presented at 10:30am on the 23rd and went to the crisis stabilization unit with signs of suicidal ideation. The patient had not been taking her medication for depression for two weeks and she had taken Ambien that morning. The patient was given Hydrocodone and Ativan when she presented to the emergency department (ED).

The patient thought that she was on the wrong medications with the incorrect dosages. The patient said that she was prescribed a medication that made her sick, so she did not take it for two weeks prior to this stay at the facility. There was a note from a nurse stating the patient was irritable about not getting her narcotic pain medications. The physician that examined her tried to contact the prescribing physician for the narcotics at the pain clinic. The hospitalist said that the patient had a history of drug seeking behavior and could not confirm a narcotic for the patient, so the facility decided to prescribe her Tylenol and Motrin and she would not take them.

A nurse provided her other methods to deal with the anxiety and depression. She wanted anxiety medications and she was told to try breathing exercises. The patient was receiving medications from a physician located an hour and a half away from where she lived because she could not get the medication locally.

There was a nurse that noted the patient's mother called and that the patient felt as though her mother had been mistreated. The patient felt that the methods in dealing with the pain were not affective and she was suffering from chronic back pain. The hospitalist could not verify the amount or frequency of the pain. Staff said that they did not review any documentation about the first blood pressure situation. The patient did start to receive blood pressure medication on the 24th in the morning. Staff took her blood pressure and it was elevated. She did receive Ativan 3 times daily as needed and she took that on the 25th and the 26th. Staff also did not see a complaint of tingling in fingers or dizziness documented in the physician or nursing notes. The patient said that her issues with blurriness were not addressed but staff stated it was addressed by a physician and it was explained that the nursing staff were not holding medications and that the physicians did not want to provide the medications. The tingling could have been related to anxiety.

Staff explained that there is a note that the patient's mother planned on filing a complaint on the 24th. The patient's mother called and said her daughter had been mistreated and the patient was given the number of the hospital advocacy department. The patient was seen yelling at the nurse's station about staff telling the patient's mom to sue the facility. Staff said that the patient was receiving the medication needed for her symptoms and was using Tylenol and appeared to be doing well. Staff were not aware of complaints filed and there was nothing filed with the complaint line. The issue was addressed by the physician who said they do not give advice regarding lawsuits. They spoke about filing the complaint. The assumption of staff was that the patient was out of control with drug seeking behavior and they were trying to set boundaries. It appears that the nursing assignment had been changed and the physician explained that the support team was still there for the patient.

Staff said that as far as they can tell, there was not a request for the patient's records. Staff would have no knowledge of what it would cost for copies of medical records. It is a quarter per page for the first few pages and there is a limit to what you can charge. Staff said that her entire record could cost a lot because of the size. If the patient wanted the complete records, it could be around 400 pages but it would not be that much for that weekend. If patients want records, they call the hospital and then they need to sign a consent. The hospital asks if the record is for a physician because then it is free due to the continuation of care but for an attorney, a fee is charged. The hospital archives records from 2014 or older and puts them on a disk which is inexpensive. They are required to keep records for 10 years. In a follow-up email, staff told the HRA that the patient's medical records were never requested by anyone or any facility. The HRA was also told that there is a flat fee for medical records of $6.50 but there is no policy where this is documented, so there would not be a per page fee. Staff also explained that there is nothing documented telling the resident to be quiet. There is only one note on the mother calling. Staff said that it was possible that the charge nurse was not being facetious and was really asking the patient to watch her blood pressure but there was no documentation.

Staff explained that in previous admissions, the patient's blood pressure was comparable to this time at the facility. Questions about whether the patient is homicidal or suicidal is asked every shift and periodically throughout the shift, especially if there are demeanor changes. Staff said that they see where this question could be asked to see how the patient is feeling.

There is documentation in the record that the patient felt like she was being disrespected. They do have to ask if she wants her medication but they do not have it documented that they asked if she was mad. Staff stated that it seems like the majority of the anger is over not getting the medication that she wanted. Typically she focused on the medication. She believed certain medications were what she needed and if she received them she was fine. Staff explained that the patient has depression but a component of the depression can be anxiety. She was being treated with an antidepressant that also has anti-anxiety components. They were trying to treat it in other ways. The physician explained the difference between the medical and psychiatric parts of the situation with the patient. They never got a report about staff gossiping. They think staff were probably talking about the situation but it was possibly a shift to shift report.

They believe that the nurse was changed but they do not know if the patient asked for the change or not. The patient did like one of the nurses. The patient requested Tylenol and, when she was admitted, she had another pill that gave her an upset stomach and that could have been associated with the Tylenol. She wanted her pain to be a 0 when usually they bring the pain down to something manageable like a 1 or a 2. The patient did report no pain relief and then another document stated that she was sleeping and it looked like she had relief from the pain. They thought that maybe they switched nurses because she was unhappy with the one involved in the report but they do not have that documented. They switched staff as per the schedule they do that if people are not connecting. Staff are pretty aware if they are not connecting with individual patients.

The staff have a code of conduct and employees receive an orientation, including a component on treatment with the online education. The orientation deals with patient treatments and patient rights. Nursing orientation deals with the expectation of handling complaints. The nurse involved in the complaint attended the one orientation dealing with complaints and one regarding customer service. There is also de-escalation training. They do mandatory abuse reporting for adults and children. They do not know why the issues were not officially addressed. When patients say that they want to speak with an advocate, they will give them the number. On the 25th in the evening she said she felt better and it was documented that she seemed better. When she was discharged she felt safe and ready to go home. The anxiety and depression was lower. There was never a complaint filed with the hospital as for as the staff knew but they said that they referred her to Illinois Guardianship and Advocacy Commission.

FINDINGS

Complaint #1 – Inhumane treatment, including rude and inadequate treatment by staff, information being withheld regarding treatment, and inadequate medication being provided to patient.

The HRA began by reviewing a note from the behavioral health department dated 9/24/2016 that was written by the nurse about whom the patient had complaints. The note reads "[Patient] feels as if she is being mistreated regarding her request for antianxiety medications and medications for pain. She has been seen by her hospitalist today and those medications have not been reordered, and the hospitalist has no plan to reorder those medications at this time. She has called her mother and made complaint with her mother. Her mother has called the unit and feels as though her daughter is being mistreated. He mother plans to file complaint with the state. [Patient] has been offered alternated pain reduction technique such as heat pack and rest, but she

feels as if these methods are of no use. She has been educated on deep breathing to help anxiety but feels as if these techniques are not effective. She has been ambulating about the unit without difficulties and has been up to use the telephone … [Patient] has been encouraged to call the Advocacy Committee has been supplied with the agency's number." Another note from the same nurse stated that the patient requested Tylenol for pain but the patient "refused rate pain and instead was verbally abusive about her care." Another note from the same nurse later that day reads "Patient just at nursing stations yelling loudly and pointing her finger. She feels as if I told her mother to sue Trinity. 'Don't you ever tell my mother to sue Trinity, I will do the suing. I already have the surgeon general working on it!' Charge nurse was able to get her to calm down and return home."

There was another note written by a nurse on 9/24/2016 at 12:39pm which reads "Client up in community room. Irritable about not getting her narcotic pain medication. [Physician] saw client. RN attempted to contact [Physician at specific pain clinic in Illinois location] per [Hospital physician] request. No emergency number available to speak with [Pain Clinic Physician]. Callers advised to go to emergency room. [Hospital Physician] ordered Tylenol or Motrin for client. Client refused both medications. Not attending unit activities. Not interacting with peers. Demanding. Client rates depression 10 on a 0 to 10 scale. Denies thoughts to harm herself or others at present. Client rates Anxiety 10 on a 0 to 10 scale. Frequently requesting medication for anxiety. Encouraged to do deep breathing exercises to help decrease anxiety. Client refused. Demanded blood pressure be checked. Manipulative. Suicide precautions maintained with Q [every] 15 minute monitoring by staff for safety. Encouraged verbalization of thoughts and feelings. Emotional support and reassurance given. Discussed current medication regimen with client. Encouraged attendance in unit activities. Mood and behavior monitored. Client is compliant with medications as prescribed." In the patient's HPI [History of Present Illness] it reads "The patient has known history of drug seeking behavior. She has history of chronic back pain and apparently goes to a doctor 1-1/2 hour away from her current place of living to get narcotic prescription. We are unable to get information from physician's office at this time. The patient is well known to the staff from previous hospital admission and had chronic issues with drug seeking behavior."

The patient's evaluation states that the patient's chief complaint is that "I need my Ativan" and "I don't get treated well when I come here." The evaluation also states that the patient sees a specific staff member outpatient. The evaluation states "The patient states that she was feeling down, depressed, sad, and hopeless. She states that she does not like how she gets treated here. However, the nurses are very good to her." The evaluation also reads "I explained to her that they cannot restart pain medicines without the doctor's consent. I explained to her that we are deferring the pain management to hospitalist." There are notes that indicate no Percocet or Ativan was not given but that the patient was given Ativan when she first entered the facility. The author of the notes states that they are unsure that the patient is taking her medication but the patient confirms she is and "The patient then said something about having to be on oxycodone, but 'I don't want to be on oxycodone. Somebody took it. I had some hydrocodone leftover, so I've been taking that, but I didn't complain, I didn't tell anybody and company came over. I can't function like this. I can't help my mom out. I'm the oldest grandchild. It's not fair. We don't have any help coming in. I don't like how I am treated here. I was at [Different Hospital].' Apparently, we did not have any beds available and she came to our ER and was sent to another facility. The patient states that they gave her something in [Other Hospital] and she states that she was allergic to it." The patient then stated she was

supposed to be on "Lexapro and Ativan." The notes also read "When I went to see the patient, she was already upset and said something about this surgeon general working on something. The patient apparently requested Tylenol for pain earlier. Again, she is not allowed to have any pain medication. The patient's mother has been calling also harassing staff, and both mother and the patient feel that the patient's needs are not being addressed. At this time, the patient is not reporting any auditory or visual hallucinations. She is definitely paranoid about staff and feeling that they are withholding medications from her … In the ER, they had to monitor her because of sedation, QT interval, and blood pressure issues … She was upset with me feeling that I am not addressing her pain issues or her anxiety. In the ER, she said something about being on wrong medicines at the wrong doses, so she stopped the medicines 2 weeks ago, but then she says she has been taking her Ativan as prescribed and she says 'I don't care for sleeping pills.' She overdosed on Doxepin and Ambien." The patient's allergies read "She supposedly is allergic to all these medicines, but there are not true allergies and they are mostly side effects. She says she is allergic to TRAMADOL, LYRICA, SEROQUEL, FLEXERIL, IBUPROFEN, DOXYCYCLINE, GABAPENTIN, and ADHESIVE TAPE. She says Tramadol causes hives. She says that Flexeril causes her to have anxiety and hallucinations." The past medical history does state that she has hypertension.

The psychiatric history part of the notes states that the patient sees a specific staff member currently but lists some physicians that she has seen in the past at the facility. The drug history reads "She definitely does abuse her pain pills, but she denies this. In the past, there have been concerns about abusing marijuana, benzodiazepine, and opiates. In the past, [Physician] assessed her and determined that she has issues with benzodiazepine and opiate use disorder along with drug-seeking behavior." In the mental status examination, it reads "She is cooperative, pleasant, and briefly interactive, but then she started crying. She was upset about her pain meds and about her benzodiazepines. She says she is stressed out, she cannot eat, she cannot sleep. She is in a lot of pain. On admission, there are suicidal ideations and she overdosed on Ambien and tricyclic antidepressant. She states that she cannot function … She feels that she is mistreated."

In the assessment and plan section of a hospitalist's note, it refers to that patient having "Chronic back pain with drug-seeking behavior. The patient requested to be places on high-dose narcotics. We were unable to confirm the dosages from physician office as the office is closed over the weekend. Give the patient's prior history of drug seeking behavior; we will not start any high-dose narcotic therapy at this time. We will try to get to physician office tomorrow to get confirmation or further details in this regard. The patient has been placed on Tylenol, Ibuprofen for asymptomatic relief of pain."

The HRA reviewed physician notes dated 9/25/2016 which states that: "The patient states that she was very upset yesterday. She said that staff was rude to her mother on the phone. However, that was not the case. Her understanding is that mother talked to staff on the phone and they told her to sue the hospital. I explained to the patient that we do not make such recommendations. The patient states that today is a better day. She states that she talked to one nurse and she was assigned another nurse and she felt content with that. I explained to the patient that the whole treatment team is here for her and nobody is against her. Yesterday, the patient might have been upset because she did not get her pain medications or her Ativan when she requested … The patient states that 'I never ring the bell and I did last night because my vision was blurry for a few seconds and nobody checked on me.' The patient admits to having an outburst. She felt that her issues were not being addressed. I explained to the patient that is

not the nursing staff that was withholding medications. I explained to her that the hospitalist decided not to do pain medicines. I explained to her that I decided about the lorazepam as the hospitalist had indicated not to do any pain medicines or benzodiazepines. I explained to her that staff is providing her medications that they were directed to give her."

In a note from the Licensed Practitioner Nurse, on 9/26/2016, it was stated that "She was offered Tylenol (which she stated didn't help) and eventually accepted." Another Registered Nurse note dated 9/25/2016 reads "Pt verbalized generalized body ache and rated her pain at 10/10 with 10 being the worst. Pt was however observed smiling and laughing and did not appear to be in any discomfort. Tylenol 650 mg oral was administered for pain per pt's request. Pt continues to be preoccupied with getting 'something better for pain.' Pt was encouraged to verbalize thoughts and feelings to seek out staff for support." In another note on 9/25/2016 written by the QMHP, it reads "Met with pt who wanted to speak about her 'outburst' last night. Pt stated that a nurse told her mother that if she had an issue with the treatment of her daughter while on the unit to sue Trinity. Pt stated that she was really embarrassed by the outburst, but she was in a lot of pain and no one will prescribe her pain meds, just Motrin and Tylenol. Pt stated that those clearly don't help her because it's not 'an everyday ache and pain.' When pt was told that this therapist cannot do anything about the medication that she has been prescribed, she stated, 'Oh I know you can't. I was hoping you could put a little bug out there in case someone decides to give me what I need.'" Another nursing note on 9/25/2016, reads "Client continues upset about treatment from second shift RN towards herself and her Mother last evening. Client's Mother called. Gave Mother complaint line number per her request. Apologized to client and her Mother for treatment by staff." The note proceeds to state that the client requested Tylenol.

A note on 9/24/2016 from Qualified Mental Health Professional state she "Met with pt who was extremely irritable and fixated on the fact that she is not receiving any pain meds or anxiety meds. Pt. stated that he mother has called the Attorney General for the abuse she has suffered at the hands of RYC providers. Pt. stated that the provider today, 'best let me out of here today if she knows what's good for her. If she doesn't, then come Monday, she will be investigated by the Attorney General also.' Pt. only wanted to focus on the lack of prescribed meds. Pt was not redirectable and became angry at this therapist when redirection was attempted."

The HRA discovered a section of the record where numbness and tingling was mentioned in the patient's left foot due to back issues but nothing else was mentioned in the record about the sensations. One of the notes stated that the patient was ordered Tylenol and Motrin but Ibuprofen is listed in the patient's allergies in the HPI (although documentation elsewhere states that the allergies are mostly side effects). The HRA did not see any documentation that the patient was given Tylenol even though she told them that it gave her an upset stomach. The HRA also saw no documentation regarding the charge nurse telling the patient to "watch your blood pressure" or that the patient was asked if she was homicidal, suicidal, or just mad at her. Additionally, the HRA saw no documentation regarding the staff gossiping or the patient being told that it would cost $400 to receive her records, or even that the records were requested.

The HRA reviewed a policy titled "Employee Conduct and Work Expectations which establishes conduct standards and sets expectations for employees to follow rules of conduct that "demonstrate professional behavior" and are consistent with the facility's mission and values and protects the "safety, interests and reputation" of all involved with the facility. The policy then illustrates some examples of workplace behavior that is "unacceptable and will not be tolerated"

and could lead to “corrective action and/or termination of employment” such as sexual or other forms of harassment, unsatisfactory work performance or conduct, use of profanity, behavior that could damage the facility image, and harassing or threatening behavior. Another “Guide to Employee Conduct” asks that staff treat patients with dignity, consideration and respect and communicate effectively with patients and family and “respond to patients’ treatment needs, requests and concerns.” The HRA reviewed another UnityPoint Code of Conduct policy that states patients will be treated with consideration and respect and each patient’s dignity will be recognized and health care needs will be met without discrimination.

The HRA reviewed the “Patient Bill of Rights and Responsibilities” policy which reads that it is the patient’s right to be treated with respect and the patient’s privacy and dignity will be maintained while “supporting a positive self-image while receiving medical care.” The rights also state patients should be made to feel safe physically and emotionally, be free from abuse and neglect and receive “considerate, respectful” care. Another right was for a patient to “receive appropriate assessment and management of pain” and to receive information on treatment options and tell staff what brings comfort and what the patient wants to do for him/herself. Regarding the complaint about the treatment of the patient’s mother, the rights state that the patient’s family can be involved with care and family or friends can be present for emotional support during the stay and present during explanations about care. Regarding the complaint that physician’s names were hidden, the rights stated that it is a patient’s right “To know the names of those responsible for authorizing and performing procedures or treatment, their professional status and the reasons for any proposed change in professional staff” and to know the names of caregivers and be informed of hospital’s relationships with other care providers.

The HRA was also provided the “Patient’s Bill of Rights” that are provided to the patient which reiterate that the patients should be treated with dignity, courtesy and respect for privacy and address concerns and be made feel comfortable. It also states “You or your loved ones should never feel harassed, abused or neglected.” Regarding the complaint dealing with healthcare records, the patient’s bill of rights states that the patients have the right to decide what information is given to who and they have the right to healthcare information, request copies of records, changes to records, and an accounting of records disclosures. A footnote reads that there “may” be a charge for records.

The HRA reviewed a blank “RN Departmental and Technical Skill Orientation Checklist” which includes items such as mandatory abuse reporting, patient rights and complaints. The HRA reviewed a list of staff members which included the nurse involved in this complaint and the nurse had completed classes in nursing orientation (2016) and employee orientation (2016).

The Mental Health and Developmental Disabilities Code requires that “(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan” (405 ILCS 5/2-102). The Medical Patient Rights Act reads “(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law” (410 ILCS 50/3).

According to the Mental Health and Developmental Disabilities Confidentiality Act, "§ 4. (a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record

or any part thereof … (2) the recipient if he is 12 years of age or older … (b) Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance. A reasonable fee may be charged for duplication of a record. However, when requested to do so in writing by any indigent recipient, the custodian of the records shall provide at no charge to the recipient, or to the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act[1] or to any other not-for-profit agency whose primary purpose is to provide free legal services or advocacy for the indigent and who has received written authorization from the recipient under Section 5 of this Act to receive his records, one copy of any records in its possession whose disclosure is authorized under this Act." (740 ILCS 110/4).

Conclusion #1

In reviewing the patient records, the HRA found no evidence of rude statements that were allegedly made by the staff, and, the staff who were interviewed said they were unaware of any such situations. The HRA did see documentation of the patient reporting that no one examined her regarding blurry vision and that the patient admitted to an outburst because of the situation but there were no documented details of the incident and no follow-up documented. There were allegations of the patient's mother stating she would sue the facility but within the documentation, those allegations were denied. There was documentation stating that the patient was assigned another nurse and was content with the decision, but there was no documentation stating that she had to keep the same nurse until a certain time. There was no documentation regarding the patient's fingers becoming tingly and numb. There was no indication in the documentation that the patient suffered for an entire day without needed medication or that she was given Tylenol even though it made her stomach upset. The HRA requested information on pricing for record copies which were not provided but the HRA also did not see documentation that the patient requested her records during her stay. Also, the HRA saw no evidence that the facility hid the name of any staff from the patient. Because of this, the HRA finds the complaints **unsubstantiated** but offers the following **suggestions:**

- Although it was stated in the documentation that the patient's allergies seemed to be more like side effects, Ibuprofen is still listed as a medication that the patient is allergic to and was prescribed in the form of Motrin. The HRA **suggests** that the facility decide whether patients have an actual allergy to medication and list the medication as an allergen or decide if the patient is suffering from side effects and take the medication off from the allergen list.
- There was confusion with staff on whether the facility charged a per page fee for medical records and it was clarified that there is only a flat fee for the records but there is no policy regarding the fee. The HRA **suggests** the facility create a policy addressing a fee for records, that includes no charge for indigent patients per 740 ILCS 110/4, so that there is no possible confusion and also assure that staff are aware of the fee in case they should be questioned by patients about prices for record copies.