

Enhancing Access

Implementation and Lessons Learned from a Hospital Based 24-Hour Urgent Care

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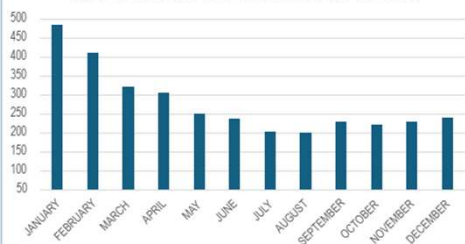
Abstract

In 2021, a large academic hospital launched a new service line: a hospital-based, 24-hour urgent care (UC) clinic designed to expand access to non-emergent care while alleviating pressure on the emergency department (ED). Upon opening of the 24-hour urgent care clinics, the emergency center began medically screening low acuity patients out of the emergency department, referring them to the urgent care clinic.

As a hospital-based service, the UC clinic benefited from significant operational advantages, including access to centralized resources such as central supply, Omnicell medication dispensing, an in-house pharmacy, radiology technologists, health unit coordinators, and system-wide registration staff. These shared services enhanced operational efficiency, enabled rapid diagnostics, and supported high-quality, streamlined care delivery.



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Staffing and Design

The clinic opened with a modest staffing model, one provider and one registered nurse (RN) in a five-exam-room facility. As patient demand grew, staffing was expanded to ensure continuous, overlapping coverage with multiple RNs, certified nursing assistants (CNAs), and providers working staggered shifts to maintain quality and throughput.

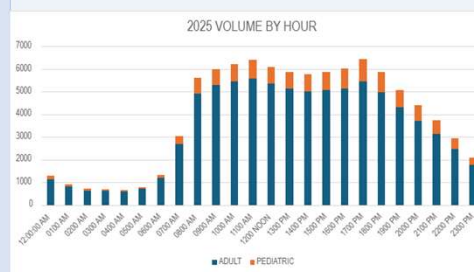
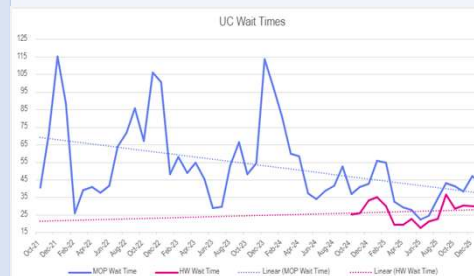
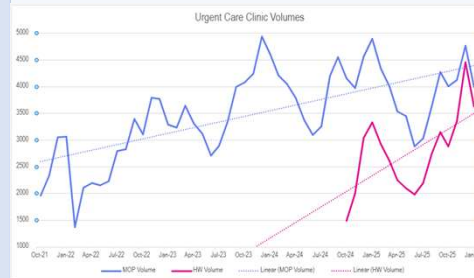
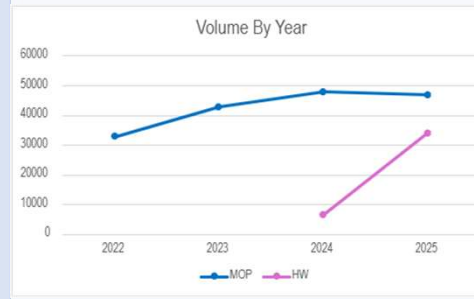
In October 2024, a second 24-hour UC clinic opened with 12 exam rooms, replicating the comprehensive staffing model and leveraging the same hospital infrastructure. In May 2025, the original clinic relocated to a larger space with 10 exam rooms to meet growing community demand.

Lesson Learned: Need For Nurse Assessment

One key operational challenge that emerged was the need for rapid clinical assessment at the front end to determine patient appropriateness for UC versus ED-level care. In response, nursing leadership developed and implemented the "Safe to Wait" protocol, a nurse-led triage initiative supported by Shared Governance and the Plan-Do-Study-Act (PDSA) quality improvement framework. This protocol enables swift identification and safe escalation of high-acuity patients (~10% of volume) to the ED, including those presenting with chest pain, stroke, sepsis, and trauma.

The protocol's success was driven by experienced RNs trained in critical thinking and assessment, who use standing delegation orders to initiate point-of-care testing and radiology at intake. This approach reduced exam room time by 30% and decreased the average length of stay (LOS) for ED transfers by 35%. Additional outcomes included increased patient satisfaction, decreased left-without-being-seen (LWBS) rates, and improvement in the clinic's Likelihood to Recommend score from 73% to 82.2%.

Data and Metrics



Key Elements

- Walk in Only Model
- RN Staffing
- Central Supply
- Central Pharmacy/Omnicell Access
- Every Patient seen, regardless of funding/ability to pay
- Hospital Registration Staffing
- Hospital Radiology Staffing
- Hospital Lab
- Stat Radiology Reads

Clinical Staffing Model

Daily Provider Staffing:

- 1x 6a-6p
- 1x 7a-7p
- 1x 11a-11p
- 1x 7p-7a

RN Staffing:

- 3 x 7a-7p
- 1x 11a-11p
- 3x 7p-7a

Nurse Aide:

- 1x 7a-7p
- 1x 11a-11p
- 1x 7p-7a

Conclusion

This care model demonstrates how a hospital-based, 24-hour urgent care service line can effectively increase access to timely care. Its success is rooted in flexible staffing, nurse-led innovation, and the integration of centralized hospital resources to support safe, efficient, and scalable urgent care delivery.

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