National Workforce & Establishment guidance for Post Anaesthetic Care Units (PACU) / Recovery Units

Foreword

Creating safe, effective, and compassionate perioperative care relies on the expertise, vigilance, and teamwork of our Post Anaesthetic Care Unit (PACU) and Recovery teams. These teams work in some of the most dynamic and high risk environments in healthcare, where rapid decision making and seamless communication are essential.

Across the UK, Recovery practitioners have consistently highlighted the need for a clear, evidence based national approach to workforce planning. Variability in staffing models, uplift, skill mix, and operational pressures has created challenges that directly affect staff wellbeing and patient safety.

This national workforce guidance has been developed in response to those challenges. It brings together best practice, professional standards, and insights from Recovery teams across the country to create a practical, usable framework for establishing safe staffing in PACU settings.

Our aim is simple: to support Recovery leaders, workforce planners, and operational teams to make informed, defensible decisions that protect patients and empower staff. By standardising expectations and providing tools that reflect the realities of modern perioperative care, we hope to strengthen the safety, resilience, and sustainability of Recovery services nationwide.

Executive Summary

Safe, effective staffing in PACU is essential to delivering high quality perioperative care. Recovery teams work in fast paced, high acuity environments where rapid deterioration, airway compromise, and complex patient needs are common. Despite this, national guidance specific to Recovery staffing has historically been limited, leading to significant variation in practice, uplift, skill mix, and operational resilience across the UK.

This national workforce guidance provides a standardised, evidence-based framework to support Recovery leaders, workforce planners, and operational managers in establishing safe staffing levels. It brings together professional standards, national recommendations, and insights from Recovery practitioners across the country to create a practical, usable model for modern PACU services.

Key components of the guidance include:

- Baseline establishment standards
- Non negotiable safety requirements
- Acuity based staffing guidance
- Skill mix expectations, outlining the roles of RNs, ODPs, HCAs, Nursing Associates, and support staff, with clear boundaries around airway management and assessment responsibilities.
- Uplift modelling, recognising the Royal College of Nursing (RCN) recommended 27% headroom and providing tools to calculate uplift based on local sickness, CPD, leave, and transfer time demands. (RCN, 2025)
- Operational considerations, including transfer times, delayed discharges, remote site recovery, and peak time pressures.
- Leadership and support structures, emphasising the supervisory role of Band 7s and the clinical oversight provided by Band 6s.
- Quality and safety indicators, such as time to discharge, incident trends, patient feedback, and staff wellbeing metrics.
- Templates and calculators, including establishment modelling, skill mix planning, acuity scoring, and business case development.

This guidance is designed to support both immediate operational decision making and long term workforce planning. It enables organisations to benchmark against national standards, identify gaps, and build robust, defensible business cases for safe staffing. By embedding consistent expectations and providing practical tools, it aims to strengthen patient safety, improve staff experience, and enhance the resilience of Recovery services nationwide.

Introduction

PACU provides immediate post operative care for patients emerging from anaesthesia. The acuity and unpredictability of this environment require a highly skilled workforce supported by clear, evidence based staffing models.

Historically, national guidance specific to Recovery staffing has been limited. Recovery teams across the UK have highlighted challenges including variable uplift, inconsistent skill mix,

increasing patient acuity, and operational pressures such as delayed transfers of care. These issues demonstrate the need for a standardised approach to workforce planning.

This document brings together national standards, professional guidance, and insights from Recovery practitioners to provide a practical framework for safe staffing in PACU settings.

Purpose of the guidance

This guideline provides a standardised, evidence based method for determining safe staffing, skill mix, uplift, and operational workforce requirements in PACU. It supports Recovery leaders and workforce planners to make defensible, data driven decisions that ensure safe, high quality perioperative care.

1. Core Establishment Standards

1.1 Baseline Staffing

Standard	Requirement
Minimum Registered Staff	1 Registered Nurse (RN) or Operating Department Practitioner (ODP) per operating theatre. Capped to the total number of Recovery bed spaces
Supernumerary duty leadership	1 Band 6 per recovery area, to provide supernumerary shift co-ordination and support
Senior Sister / Charge Nurse / Team Leader	The Registered Lead will be 100% supervisory and not counted in the numbers as part of the workforce allocation (RCN 2025)
Minimum Safe Staffing	Never fewer than 2 Registered staff present
Lone Working	Not permitted

Rationale: Even patients who meet discharge criteria can deteriorate rapidly. Two staff are required for safety, manual handling, safeguarding and chaperoning, as well as emergency response.

1.2 Remote Site Recovery (MRI, Interventional Radiology, In-theatre Recovery)

Requirement	Detail
Minimum staffing	2 Registered, airway trained staff at all times
Exception	May reduce if the anaesthetist remains present throughout recovery
Lone working	Not permitted

Rationale: Even patients who meet discharge criteria can deteriorate rapidly. Two staff are required for safety, manual handling, safeguarding and chaperoning, as well as emergency response.

2. Special Considerations

2.1 Complex Needs (LD, Autism, Behavioural Needs)

- May require 2 Registered staff
- Can be supported by supernumerary Band 6 or HCA depending on clinical need

2.2 High Flow Lists (e.g., ENT airway lists)

- Recovery time may exceed surgical time
- Additional Registered staff required

2.3 Paediatric Recovery

Stage	Ratio
Immediate post-op	2 practitioners, at least one RN/ODP
Once awake & calm	May reduce based on clinical judgement

2.4 Critical Care / High Acuity Cases

- Additional Registered staff required
- Consider HDU competent practitioners

3. Nurse to Patient Ratios

Patient Type	Ratio	Notes
Adult	1:1	Until airway control regained and stable
Paediatric	2:1	Until awake and parents present
Ward ready patients	Max 1:4 ratio	May cohort
Patients requiring airway support, IV opioids, or with acuity concerns	Must remain 1:1	Non-negotiable

Cohorting: Used only to protect 1:1 care for higher acuity patients.

4. Break Provision & Peak Time Staffing

4.1 Breaks

- Establishment must allow breaks without delaying theatre flow
- Consider additional staff during peak times
- Use occupancy audits to identify high demand periods

4.2 Peak Time Challenges Identified Nationally

- Afternoon surges
- Delayed transfers
- High sickness rates
- Late discharges
- Twilight staffing gaps

Recommended Feature: Bed space occupancy and activity heat mapping.

5. Uplift Requirements

Uplift Type	Recommended	National Reality
RCN Standard	27%	Most units at 21–23%
Purpose	Covers sickness, CPD, leave, supervision	Financial constraints limit compliance

Recommendation: Include a configurable uplift calculator with RCN benchmarking.

6. Skill Mix Requirements

6.1 Registered Staff

- RNs and ODPs may work interchangeably where competencies align
- All staff must meet PACU competency standards

6.2 Support Staff

Role	**Scope**
Band 2	Portering, non-patient care tasks
Band 3	Direct care without assessment responsibilities
Nursing Associates	Cannot care for patients requiring airway support

7. Leadership and Support Roles

Role	**Expectation**
Band 7	Supervisory, not counted in numbers
Band 6	Supernumerary clinical expert in each area
Coordinators	Support breaks, peak-time workload, escalation

8. Transfers and Geography

8.1 Transfer Time Impact

Transfer times vary from **5–30 minutes** depending on:

- Distance to wards
- Patient complexity
- Number of cases

Example: 10 complex cases × 30 mins = 5 hours of staff time away from PACU.

Recommendation: Audit transfer time to calculate uplift requirements

9. Acuity-Based Staffing

Current State:

- Rarely used formally
- Desired by most units
- Paediatrics uses it most consistently

Recommendation: Include an acuity scoring system with:

- Adult / paediatric categories
- Airway risk
- Behavioural risk
- Critical care needs
- High flow list indicators

10. Quality Indicators

Suggested metrics:

- Time to discharge
- Incident reporting trends
- Patient feedback
- Delayed transfer numbers
- Staff wellbeing indicators

11. Training and Competency

National Themes:

- Supernumerary periods: 8–12 weeks
- Mandatory airway assessments

12. On-Call Staffing

- Must comply with employer terms & conditions
- On call models vary nationally, but must meet national standards with regards to rest periods

References

Royal college of Anaesthetists (2025*) Chapter 2: Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients*. Available at: https://www.rcoa.ac.uk/gpas/chapter-2#chapter-9 *(Accessed: 6th March 2026)*

Royal College of Nursing (2025) *Nursing Workforce Standards: Supporting a safe and effective nursing workforce. RCN: London*. Available at: https://www.rcn.org.uk/Professional-Development/publications/rcn-nursing-workforce-standards-uk-pub-011-930 (Accessed: 6th March 2026)

Acknowledgements

This guidance would not have been possible without the insight, honesty, and expertise of Recovery practitioners, theatre teams, managers, and clinical leaders from across the UK. Their contributions, through surveys, interviews, round table discussions, and shared experiences, have shaped every aspect of this work.

We extend our sincere thanks to:
- The Recovery nurses, ODPs, and educators who shared their challenges and innovations during the BARNA roundtable event
- The Recovery leaders who provided detailed operational insight
- Workforce, HR, and organisational development colleagues who contributed data and modelling expertise
- Lena Johnson (RCN Workforce lead)
- The teams who piloted early versions and provided invaluable feedback

Most importantly, we acknowledge the patients whose safety and wellbeing remain at the heart of this work. Their experiences remind us why safe staffing, strong leadership, and a supportive culture in Recovery are essential.

© 2026 British Anaesthetic and Recovery Nurses Association. All rights reserved. This document is designed to be used in conjunction with local organisations risk assessment processes. Workforce & Establishment guidance for Post Anaesthetic Care Units (PACU) / Recovery Units.