2026 SOAP CENTER OF EXCELLENCE DESIGNATION APPLICATION

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I. General Information and Center/Institution Details

I1. Leadership: Name and email of the Lead Obstetric Anesthesia Attending (Faculty or Group Lead)

I2. Credentials/Degree

I3. Name and Email of Department Chair, or group Lead

I4. Name of Center/Institution

This application is for a single physical site, a single obstetric unit and its supporting units, not a hospital system.

I5. Name of Anesthesia Group, if applicable. If not applicable, type not applicable.

I6. Address of Center/Institution
Street

City

State

Zip Code/Postal Code

Country

I7. What is your Center/Institution's current application status

Select the appropriate answer

- ◯ First time applying for COE designation
- ◯ Recertification (i.e. previously received COE certification)
- ◯ Previously applied without success (but with fee waiver for reapplication)
- ◯ Previously applied without success

I8. Describe the Center/Institution type for which this application is submitted.
This is a key question that will inform the review process

Tertiary/Referral Center (transfers "in" for specialty maternal care)

Select the appropriate answer

- ◯ Yes
- ◯ No

I9. Describe your Center/Institution as a training program

Select all appropriate answers

- ☐ Train/teach anesthesiology residents
- ☐ Train/teach obstetric anesthesiology fellows
- ☐ Train/teach other learners (student nurse anesthetists, anesthesiology assistants, medical students, etc.)

- ☐ Has an ACGME-accredited OB Anesthesiology fellowship program
- ☐ None

I10. What level of maternal care does your Center/Institution provide according to the American College of Obstetricians and Gynecologists (ACOG) level of maternal care (Level 1,2, 3, or 4)?

Select the appropriate answer

- ◯ Level 2
- ◯ Level 3
- ◯ Level 4
- ◯ Not applicable (International Center/Institution)

I11. What is the total number of **annual deliveries** in your Center/Institution's obstetric unit?

Please indicate number only.

I12. What is the total number of **labor and delivery rooms** in your Center/Institution's obstetric unit?

Please indicate number only.

I13. What is the total number of dedicated **operating rooms** in your Center/Institution's obstetric unit?

Please indicate number only.

I14. **Essential Element:** Does your Center/Institution use an electronic medical record (or equivalent) as the anesthesia record for labor analgesia, cesarean deliveries and all other obstetric procedures involving anesthesia?

Select the appropriate answer

- ◯ Yes
- ◯ No, please describe how anesthesia procedures are documented and tracked and how quarterly dashboards are monitored.

II. Personnel, Staffing and Coverage

II1. Obstetric Anesthesiology Leadership

II1A. **Essential Element:** Outline the expertise and experience of your Center/Institution's Lead Obstetric Anesthesia Attending (Faculty or Group Lead)

Suggested word count of 200-300 words.

Please attach the Curriculum Vitae of the Lead Obstetric Anesthesia Attending (Faculty or Group Lead) to this application.

II1B. What is the total administrative/non-clinical time that the Center/Institution is allocating to the Lead Obstetric Anesthesia Attending (Faculty or Group Lead) ?

Please only indicate the percentage time (do not add % sign) – example 10 or 20

II 2. Obstetric Anesthesiology Staffing

II2A. **Essential Element:** Please indicate the total number of anesthesiologists (attendings/Faculty or supervising attending anesthesiologists) who provide care to obstetric patients in your Center/Institution's obstetric unit

Please indicate the number only

II2B. **Essential Element:** Of these, how many are obstetric anesthesia specialists? Obstetric anesthesia specialists are anesthesiologists who are fellowship-trained obstetric anesthesiologists or part of a core group of anesthesiologists who specialize in obstetric anesthesia.

Please indicate the actual number of obstetric anesthesia specialists

II2C. **Essential Element: During the weekday daytime**
How many anesthesia staff are assigned to provide dedicated coverage in your Center/Institution's obstetric unit?

Please indicate the number only (enter 0 when appropriate)

Attending Anesthesiologist:

Fellow:

Resident (trainee):

Certified Registered Nurse Anesthetist (CRNA) / Certified Anesthesiologist Assistants (CAA):

II2D. **Essential Element: During the weekday nighttime**
How many anesthesia staff are assigned to provide dedicated coverage in your Center/Institution's obstetric unit?

Please indicate number only (enter 0 when appropriate)

Attending Anesthesiologist:

Fellow:

Resident (trainee):

Certified Registered Nurse Anesthetist (CRNA) / Certified Anesthesiologist Assistant (CAA);

II2E. **Essential Element: During the weekend/holiday daytime**
How many anesthesia staff are assigned to provide dedicated coverage in your Center/Institution's obstetric unit?

Please indicate number only (enter 0 when appropriate)

Attending Anesthesiologist:

Fellow:

Resident (trainee):

Certified Registered Nurse Anesthetist (CRNA) / Certified Anesthesiologist Assistant (CAA);

II2F. **Essential Element: During the weekend/holiday nighttime**
How many anesthesia staff are assigned to provide dedicated coverage in your Center/Institution's obstetric unit?

Please indicate number only (enter 0 when appropriate)

Attending Anesthesiologist:

Fellow:

Resident (trainee):

Certified Registered Nurse Anesthetist (CRNA) / Certified Anesthesiologist Assistant (CAA);

I2G. **Essential Element:** Estimate the proportion of each shift covered by Attending Anesthesiologists who are specialists in obstetric anesthesia vs. generalists.

Please indicate number only (enter 0 when appropriate)

Weekday Daytime

Weekday Nighttime

Weekend/holiday Daytime

Weekend/holiday Nighttime

II 3 Supervision of physician trainees (residents and fellows)

II3A. **Essential Element:** Does the supervising attending anesthesiologist see each patient in person before placement of neuraxial labor analgesia, neuraxial anesthesia, or induction of general anesthesia?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II3B. **Essential Element:** Is the supervising attending anesthesiologist informed, reviewing and approving provision of neuraxial labor analgesia and involved in all medical decision-making?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not Applicable

II3C. **Essential Element:** For physician trainees (residents and fellows), is the supervising attending anesthesiologist present for the placement of all neuraxial labor analgesia procedures?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II3D. **Essential Element:** For physician trainees (residents and fellows), is the attending anesthesiologist present for the placement of all neuraxial anesthetics in the obstetric operating rooms?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II3E. **Essential Element:** For physician trainees (residents and fellows), is the attending anesthesiologist present for the induction of all general anesthetics in the obstetric operating room?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II3F. **Essential Element:** For physician trainees (residents and fellows), if the supervising attending anesthesiologist is not present in the operating room when a surgical issue arises (example: postpartum hemorrhage, intraoperative pain), describe the process to alert them.
Is there a specific protocol or trigger to call the supervising attending anesthesiologist?

II3G. At international centers, where the training period is longer and regulations differ, and "structured independence" is introduced, is there a minimum number of years required prior to independently performing neuraxial procedures and is there a specific process or policy to notify the supervising attending anesthesiologist in the event of a difficult procedure or other complication, such as unintended dural puncture and requirements for epidural catheter replacement?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II 4 Supervision of Certified Registered Nurse Anesthetist (CRNA) and Certified Anesthesiologist Assistant (CAA)

II4A. **Essential Element:** Does the supervising attending anesthesiologist see each patient in person before placement of neuraxial analgesia, neuraxial anesthesia, or induction of general anesthesia?

Select the appropriate answer

- ◯ Yes

- ◯ No
- ◯ Not applicable

II4B. **Essential Element:** Does the supervising attending anesthesiologist review the chart of each patient before placement of neuraxial analgesia, neuraxial anesthesia, or induction of general anesthesia by the CRNAs/CAAs?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II4C. **Essential Element:** Is the supervising attending anesthesiologist informed by the CRNAs/CAAs, reviewing and approving provision of neuraxial labor analgesia and involved in all medical decision-making ?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II4D. **Essential Element:** Is the supervising attending anesthesiologist present for the placement of all **neuraxial labor analgesia procedures** by CRNAs/CAAs?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II4E. **Essential Element:** Is the supervising attending anesthesiologist present for the placement of all neuraxial anesthetics by CRNAs/CAAs in the **operating room**?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II4F. **Essential Element:** Is the supervising attending anesthesiologist present for the induction of all general anesthetics in the obstetric operating room, when performed by CRNAs/CAAs?

Select the appropriate answer

- ◯ Yes
- ◯ No
- ◯ Not applicable

II4G. **Essential Element:** If the supervising attending anesthesiologist is not present during a neuraxial labor analgesia procedure placed by CRNAs/CAAs, describe the process to alert the attending anesthesiologist during a difficult procedure (for example how many attempts or time elapsed since starting a neuraxial procedure) or complications (unintentional dural puncture).
Is there a specific protocol for nurses to call the supervising attending anesthesiologist if needed?

If not applicable, type not applicable.

II4H. **Essential Element:** If the supervising attending anesthesiologist is not present **in the operating room** when a surgical issue arises (example: postpartum hemorrhage, intraoperative pain), describe the process to alert them.
Is there a specific protocol or trigger to call the supervising attending anesthesiologist?

If not applicable, type not applicable.

II4I. **Essential Element:** Describe what CRNAs/CAAs do independently

If not applicable, type not applicable

II 5 Supervision of Students including Medical Students, Student Nurse Anesthetists, and any other students

II5A. **Essential Element:** Please confirm that students of any type are never allowed to perform any neuraxial procedure without a supervising attending anesthesiologist being present?

Select the appropriate answer

- ◯ They are not allowed to perform unsupervised procedures
- ◯ Other (explain)

II 6 Supervising Attending Anesthesiologist Presence at Rounds

II6A. Is the supervising attending anesthesiologist regularly present for multidisciplinary rounds and/or sign- out rounds on the obstetric unit?

Select the appropriate answer

- ◯ Yes
- ◯ No

II 7 Dedicated Supervising Attending Anesthesiologist Coverage

II7A. **Essential Element:** Does the supervising attending anesthesiologist assigned to the obstetric unit have responsibilities of coverage of operating rooms outside of the obstetric unit?
If yes, please describe further what the responsibilities are and when the supervising attending anesthesiologist covering the obstetric unit has these additional responsibilities.

Select the appropriate answer

- ◯ Yes
- ◯ No

B. **Essential Element:** Does the supervising attending anesthesiologist assigned to the obstetric unit have responsibilities of coverage for airway emergencies or codes outside of Maternal Health?
If yes, please describe further what the responsibilities are and when the supervising attending anesthesiologist covering the obstetric unit has these additional responsibilities.

Select the appropriate answer

- ◯ Yes
- ◯ No

II 8 Backup System

II8A. **Essential Element:** Outline the backup system to obtain assistance on the obstetric unit if needed, including who would come to assist and the time frame in which they would arrive.

II 9 Anesthesia Technicians & Other Support Staff

II9A. Please describe anesthesia technician and other support staff availability on the obstetric unit

III Obstetric Anesthesia Metrics

III 1 Neuraxial Labor Analgesia

III1A. **Essential Element:** What is the neuraxial labor analgesia rate ("labor epidurals")? Please report the annual number of neuraxial labor analgesia procedures

Please only indicate the rate (do not add % sign)

III1B. **Essential Element:** What is the neuraxial labor analgesia replacement rate? (this is the 1st metric)

Please report the annual number of replacement procedures during labor (in the labor room)

Please only indicate the rate (do not add % sign)

III 2 Unintended Dural Puncture, Postdural Puncture Headache, and Epidural Blood Patch

III2A. **What is the total number of annual neuraxial procedures using an epidural needle?**
This is the sum of all epidurals, dural puncture epidurals (DPEs) and combined spinal epidurals (CSEs) procedures for neuraxial labor analgesia or cesarean delivery anesthesia (or other procedures)

Please indicate the number

III2B. **Essential Element:** What is the total annual **unintended dural puncture ("wet tap) rate** in the obstetric setting? **(This is the 2nd metric)**

Calculate using the number of unintended dural punctures divided by the number of total epidural/DPE/CSE procedures you indicated above

Please only indicate the rate (do not add % sign)

III2C. **What is the total annual number of neuraxial procedures (using an epidural needle and/or spinal needle?**
This the sum of all neuraxial procedures (all epidurals/DPE/CSE procedures for neuraxial labor analgesia or cesarean delivery anesthesia or other procedures and all spinal procedures for neuraxial labor analgesia or cesarean delivery anesthesia or other procedures)

Please indicate the number

III2D. **Essential Element:** What is the annual number of patients with postdural puncture headache (PDPH) in the obstetric setting

Please indicate the number

III2E: **Essential Element:** What is the annual **postdural puncture headache (PDPH) rate** in the obstetric setting?

This should include PDPH from unintended dural punctures as well as PDPH from spinal procedures

Calculate using the annual number of patients with PDPH divided by the total number of neuraxial procedures (epidural/DPE/CSE/spinal) you indicated above

Please only indicate the rate (do not add % sign)

III2F. What is the annual number of de novo epidural blood patch (EBP) for treatment of PDPH in the obstetric setting

Please indicate the number

III2G. **Essential Element:** What is the annual epidural blood patch (EBP) rate in the obstetric setting?

Calculate by using the number of de novo EBP performed divided by the total number of PDPH in the obstetric setting

Please only indicate the rate (do not add % sign)

III2H. **Essential Element:** all patients with unintended dural puncture, PDPH and /or epidural blood patch must appropriately be followed by the obstetric anesthesia team or referred to the acute pain service (ideally until resolution of symptoms)

Please describe the patient follow-up process.

III2I. **Essential Element:** A quality assurance review of all unintended dural punctures and PDPH must be in place.

Please describe your quality assurance review method.

III 3 General Anesthesia for Cesarean Delivery

III3A. What is the annual total cesarean delivery rate?

Please only indicate the rate (do not add % sign)

III3B. **Essential Element:** What is the general anesthesia rate for all cesarean deliveries (including complex surgical cases and cesarean hysterectomy cases)? **(this is the 3rd metric)**

Please only indicate the rate (do not add % sign)

III3C. **Essential Element:** What is the **general anesthesia rate for scheduled cesarean delivery cases** (non-laboring, elective)?

Calculate by using the number of general anesthetics for scheduled cases divided by the number of scheduled cesarean delivery cases

Please only indicate the rate (do not add % sign)

III3D. **Essential Element:** What is the **general anesthesia rate for unscheduled cesarean delivery cases** (intrapartum, urgent, stat)?

Calculate by using the number of general anesthetics for unscheduled cases divided by the number of unscheduled cesarean delivery cases

Please only indicate the rate (do not add % sign)

III3E. **Essential Element:** Is there a quality assurance review of all cases requiring general anesthesia (irrespective of your Center/Institution's general anesthesia rate)? Please provide (attached with the application) evidence of your quality assurance review process.

Select the appropriate answer

- ◯ Yes
- ◯ No

IV Labor Analgesia (Neuraxial and Other Forms)

IV 1 Standardization of neuraxial labor analgesia procedures (needles, catheters, and medication solutions and delivery)

IV1A. **Essential Element:** Outline the routine utilization of a small-gauge pencil-point needle for the provision of CSE or DPE labor analgesia. Please specify the type of needle and gauge.

IV1B. Describe how standardized epidural solutions are provided and used by all anesthesia providers.
Please indicate if epidural solutions are pre-mixed by the pharmacy.

IV1C. **Essential Element:** What is the standard epidural solution?
Please indicate the local anesthetic, its concentration, and lipophilic opioid (μg/mL)
Please indicate if different solutions are available.

IV1D. Please describe how your labor epidural maintenance analgesia is maintained.

Select the appropriate answer(s)

- ☐ Programmed intermittent bolus (PIEB) with patient-controlled epidural analgesia (PCEA)
- ☐ Continuous epidural infusion (CEI) with PCEA
- ☐ Other, please describe.

IV1E. Describe your routine utilization of flexible (wire-reinforced) epidural catheters for labor analgesia.

IV 2 Responsiveness to the Request for Neuraxial Labor Analgesia ("Epidural Request")

IV2A. Do you have a system in place to ensure that patients' requests for epidural analgesia are addressed within 30 minutes?

Please describe.

IV 3 Neuraxial Techniques

IV3A. Please report the breakdown of all neuraxial labor analgesia techniques, with the total equaling 100%.

Please only indicate the rate (do not add % sign), enter 0 when appropriate

Standard Epidurals

Dural puncture epidurals (DPE)

Combined spinal epidurals (CSE)

Single shot spinal analgesia

Continuous spinal analgesia with intrathecal catheter (whether intended or after unintended dural puncture)

IV 4 Regular Assessment of Labor Analgesia

IV4A. **Essential Element:** Describe the process of "active management of labor epidural analgesia" and how adequacy of neuraxial labor analgesia is assessed ("epidural rounding" frequency).

IV4B. **Essential Element:** Outline the management of breakthrough pain with labor epidural analgesia (assessment of block, functionality of indwelling catheter and medication delivery system). Describe use of epidural top ups including circumstances, composition of local anesthetic, and type of adjuvants used.

Please upload protocol/algorithm for epidural top-ups if available

IV4C. Describe the ongoing monitoring with labor epidural analgesia (e.g. blood pressure, assessment of motor/sensory levels) and protocols to manage potential side effects or complications associated with neuraxial analgesia.

IV 5 Non-Neuraxial labor analgesia options

IV5A. Describe intravenous patient-controlled analgesia (PCA) options offered, and outline protocol specifics including opioids available (e.g., remifentanil, fentanyl), administration settings (e.g., continuous infusion, PCA, both) and monitoring requirements.

IV5B. Outline the availability of nitrous oxide for labor analgesia, and if available provide protocol specifics.

V Cesarean Delivery Management

V 1 Enhanced Recovery after Cesarean Delivery (ERAC) Protocol

V1A. **Essential Element:** Confirm your Center/Institution's implementation of enhanced recovery elements as defined by in the 2021 SOAP Enhanced Recovery After Cesarean (ERAC) Consensus Statement and updated in the 2025 SOAP/ACOG recommendations.

Select all appropriate answers (details will be provided in next questions)

- ☐ Standardized use of pencil-point spinal needles
- ☐ Standardized prevention of spinal hypotension
- ☐ Standardized protocol for temperature management
- ☐ Standardized antibiotic prophylaxis
- ☐ Standardized prevention of nausea and vomiting
- ☐ Standardized prevention and treatment of shivering and pruritus
- ☐ Standardized protocol for uterotonics
- ☐ Standardized opioid-sparing multimodal analgesia
- ☐ Standardized approach to prevent, mitigate, treat, document, and audit pain during cesarean delivery
- ☐ Protocol for patients with opioid use disorder

V 2 Spinal Needles

V2A. **Essential Element:** Outline your routine utilization of a pencil-point needle (25-gauge or smaller) for the provision of spinal and CSE anesthesia for cesarean delivery.

V 3 Spinal Hypotension Prevention and Treatment

V3A. **Essential Element:** Please describe your Center/Institution's standardized approach to **prevent** spinal hypotension

Select the appropriate answer

- ◯ Continuous infusion of phenylephrine (started with spinal anesthesia administration)
- ◯ Continuous infusion of norepinephrine (started with spinal anesthesia administration)
- ◯ Other, please describe

V3B. **Essential Element:** Please describe how spinal hypotension is **treated**.

V 4 Temperature Management

V4A. **Essential Element:** Outline strategies to prevent maternal and neonatal hypothermia. (active warming, warm intravenous fluids, appropriate ambient delivery/operating room temperature).

V4B. Describe your Center/Institution's approach to measure and document maternal temperature during general and neuraxial anesthesia.

V 5 Antibiotic Prophylaxis - Surgical Site Infection Prevention

V5A. **Essential Element:** Describe your Center/Institution's antibiotic prophylaxis protocols, specifically how the following are ensured: timely administration (prior to skin incision) of appropriate antibiotic(s); implementation of a weight-based dosing approach; implementation of an appropriate redosing strategy; identification of alternatives if allergies are known/detected; and consideration of additional antibiotics if applicable for high-risk patients.

V5B. Outline which antibiotics are stored in the operating room for emergency cesarean deliveries,and describe how additional antibiotics are acquired urgently from pharmacy.

V 6 Prevention of Nausea and Vomiting

V6A. **Essential Element:** Describe your Center/Institution's approach to risk stratification of patients regarding perioperative nausea and vomiting.

V6B. **Essential Element:** Outline your Center/Institution's perioperative antiemetic prophylaxis and treatment protocol.

V 7 Prevention and Treatment of Shivering and Pruritus

V7A. Outline your Center/Institution's protocol to prevent shivering and which medications are immediately available for treatment of shivering (e.g. dexmedetomidine, clonidine, etc.) in the operating room and in the post-anesthesia care unit.

V7B. Outline your Center/Institution's protocol for treatment of pruritus (e.g., nalbuphine) in the operating room and in the post-anesthesia care unit.

V 8 Uterotonics

V8A. Outline your protocol for oxytocin and secondary uterotonics (e.g., methylergonovine, prostaglandins, calcium) and other medication (e.g., tranexamic acid),

Please attach your Center/Institution's oxytocin protocol (if available) to this application

V 9 Multimodal Analgesia Protocols

V9A. **Essential Element:** Outline your Center/Institution's post-cesarean delivery analgesic protocol.
Provide details on the routine use of long acting neuraxial opioids (e.g., morphine) and scheduled and prn medications (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs)

V9B. Describe your ability to provide local anesthetic wound infusions or regional nerve/fascial plane blocks when appropriate. Are regional blocks performed by obstetric anesthesia providers or the acute pain/regional anesthesia service?

V 10 Intraoperative Pain During Cesarean Delivery

V10A. **Essential Element:** Outline when and how neuraxial blocks are tested before skin incision and strategies/protocols used to ensure blocks are adequate for surgery (including for intrapartum cesarean delivery).

V10B. **Essential Element:** Outline strategies/protocols to treat intraoperative pain (e.g., IV analgesic supplementation, other) and if known, please indicate the percentage of patients receiving IV analgesic supplementation (e.g. fentanyl, morphine, ketamine, dexmedetomidine, other) at your institution.

If available, please attach your Center/Institution's specific protocol for management of intraoperative pain during cesarean delivery

V10C. **Essential Element:** Describe the patient follow-up for those who experienced intraoperative pain.

V10D. **Essential Element:** Describe your Center/Institution's approach to documenting, recording and reviewing (QA) cases of pain during cesarean delivery.

Pain during cesarean delivery is a patient-reported outcome. However, administration of unplanned medication (IV-adjuvants) may serve as an approximate surrogate.
Identifying patients who have received IV medication adjuvants is feasible in electronic health records.
Please indicate what recent QI processes have been implemented to identify patients who experienced pain during cesarean delivery, and what your Center/Institution is implementing to prevent, manage and follow such cases.

V 11 Management of Patients with Opioid Use Disorder

V11A. **Essential Element:** Describe your Center/Institution's protocol or plan of action to manage patients with opioid use disorder, and/or chronic pain.
If available, please attach your Center/Institution's specific protocol for management of patients with OUD who are undergoing cesarean delivery

VI Postpartum Management and Neonatal Care

VI 1 Management and risk of respiratory depression

VI1A. Describe your approach to identify patients at increased risk for respiratory depression, and screening for obstructive sleep apnea.

VI1B. **Essential Element:** Describe your Center/Institution's protocol (and order set) for monitoring and treatment for respiratory depression after cesarean delivery.
Patients are assumed to have received neuraxial opioids and respiratory monitoring should be consistent with SOAP guidelines (e.g., monitoring should be risk-stratified).

VI 2 Efforts to minimize opioid consumption

VI2A. **Essential Element:** Outline your Center/Institution's efforts to limit the number of opioid tablets that are prescribed for in-hospital use (e.g. <30 mg oxycodone/24 hours), and all non-opioid rescue analgesic options (e.g. transversus abdominis plane blocks).

VI2B. **Essential Element:** Outline your Center/Institution's efforts to limit the number of opioid tablets prescribed at hospital discharge (e.g. 10-20 tablets).

VI 3 Baby Friendly

VI3A. Describe how your anesthesiology service supports baby-friendly practices such as breastfeeding and chestfeeding (e.g., ability to safely facilitate skin-to-skin in the operating room or recovery unit, when possible).

VI 4 Neonatal Resuscitation

VI4. Outline how an in-house (24/7) clinician (separate from the anesthesiology service) with appropriate training to provide neonatal resuscitation is available.

VI 5 Postpartum Reproductive Care and other Urgent Procedures

VI5A. Describe your Center/Institution's ability to provide anesthesia care for postpartum tubal ligation procedures within 24 hours of delivery, and urgent cerclage placement within 12 hours of surgical request.

Outline policies/procedures to ensure postpartum tubal ligation procedures are prioritized and performed in a timely manner as per ACOG recommendations.

VI5B. Describe your Center/Institution's ability to provide anesthesia care for urgent cerclage placement within 12 hours of surgical request.

VII Obstetric Hemorrhage Management

VII 1 Protocols and Policies

VII1A. Outline your hemorrhage risk stratification algorithm and management protocol.

Please attach your Center/Institution's protocols related to risk stratification and management of obstetric hemorrhage to this application.

VII1B. **Essential Element:** Briefly describe and provide your institution's obstetric hemorrhage toolkit (including massive transfusion protocols, checklists and/or algorithms).

Please attach your Center/Institution's massive transfusion protocol or checklist/algorithms related to the management of obstetric hemorrhage to this application.

VII1C. Outline how obstetric blood loss is recorded (quantitative versus estimated blood loss) and how the incidence of postpartum hemorrhage is tracked.

VII1D. **Essential Element:** Describe your Center/Institution's obstetric hemorrhage quality assurance (QA) review process. Describe triggers to review cases.

VII1E. **Essential Element:** Outline your policies/procedures for suspected abnormal placentation (e.g. placenta accreta/percreta) cases.
Describe the location (obstetric or main operating suite), staffing (e.g., obstetric anesthesia specialists), planning process (e.g., multidisciplinary meeting), and other considerations (e.g., blood management) for these cases.
If appropriate for your facility, please describe criteria which would prompt transfer of these patients to a facility with a higher level of care.

VII1F. Describe your Center/Institution's approach to managing patients who refuse blood transfusion identified prior to presenting for delivery, counseled regarding blood product options, and prepared or optimized for delivery. For example, indicate if cell salvage is readily available 24/7, or if available but only for scheduled cases, and if applicable where it is located.

If appropriate for your facility (referring center), please describe criteria which would prompt transfer of these patients to a facility with a higher level of care.

VII 2 Equipment for Management of Obstetric Hemorrhage

VII2A. **Essential Element:** Describe your type, number, and location of rapid-infuser devices to assist with massive hemorrhage resuscitation (e.g. Belmont® Rapid Infuser, Level 1® Fast Flow Fluid Warmer).

VII2B. Outline plans for difficult peripheral and/or central intravascular access, e.g. ultrasound and intraosseous kits available.

VII2C. Describe your Center/Institution's ability to obtain laboratory values quickly, such as point-of-care equipment to assess hematocrit and/or coagulation.

Please indicate if thromboelastography (TEG®), thromboelastometry (ROTEM®), sonorheometry (Quantra) or other viscoelastic monitoring technology are available to guide management, and please indicate their location.

Please select the appropriate answers(s)

- ☐ Thromboelastography (TEG®) on the obstetric unit
- ☐ Thromboelastography (TEG®) off the obstetric unit
- ☐ Thromboelastometry (ROTEM®) on the obstetric unit
- ☐ Thromboelastometry (ROTEM®) off the obstetric unit

- [ ] Sonorheometry (Quantra) on the obstetric unit
- [ ] Sonorheometry (Quantra) off the obstetric unit
- [ ] None available

VII2D. **Essential Element:** Outline availability of intraoperative cell salvage for patients who refuse banked blood, and/or during high-risk cesarean deliveries.

VIII Airway Management and Emergency Resources

VIII 1 Airway Management

VIII1A. **Essential Element:** Outline your difficult airway supplies: laryngoscopes, endotracheal tubes, rescue airway devices (e.g. supraglottic airway device(s), video-laryngoscope(s) and surgical airway equipment) that are stored on the obstetric unit. Describe the use of videolaryngoscopy in your obstetric unit for general anesthesia for cesarean delivery cases (e.g. not routinely used, sometimes, routinely, always).

VIII1B. **Essential Element:** Describe your obstetric-specific difficult airway protocol and confirm where it is displayed (e.g. on the difficult airway cart, in obstetric operating rooms, other)

VIII1C. **Essential Element:** Describe whether your obstetric unit has immediately available dedicated suction and means to deliver positive pressure ventilation and supplemental oxygen (e.g. bag valve mask device) in locations where neuraxial analgesia/anesthesia and/or general anesthesia are administered, including in labor rooms where labor neuraxial analgesia is administered.

VIII1D. Describe what the plan is for a cannot ventilate/cannot intubate scenario? Is there personnel in-house or on call who can provide a surgical airway? If so, 24/7? Please provide speci cs.

VIII 2 Emergency Resources

VIII2A. **Essential Element:** Outline your Center/Institution's local anesthesia systemic toxicity (LAST) protocol, lipid emulsion (IntralipidTM) availability (indicate if on the obstetric unit or not), appropriate supplies, and protocol that allow a timely response to local anesthetic systemic toxicity.

VIII2B. **Essential Element:** Outline your Center/Institution's malignant hyperthermia (MH) protocol, availability and location of dantrolene formulations and sterile water vials and other supplies.

VIII2C. **Essential Element:** Outline all cognitive aids and training to facilitate team member awareness of resources and their location to manage all emergencies on the obstetric unit (e.g. for LAST or MH management)

VIII2D. Outline availability and usage by obstetric anesthesia providers of ultrasound devices for peripheral and central venous access, neuraxial blocks, regional plane blocks, and point-of-care evaluations (e.g. gastric, abdominal, lung, and cardiac).

IX Multidisciplinary Team-based Approach and Institutional Resources

IX 1 Communication

IX1A. Outline the system in place to screen and identify all high-risk patients PRIOR TO ADMISSION (in the antenatal period). Discuss early evaluation by the anesthesia team of high-risk antenatal patients PRIOR TO ADMISSION for scheduled surgery or labor and delivery (e.g. high-risk anesthesia clinic).

1X1B. **Essential Element:** Describe systems in place to ensure inter-professional communication and situational awareness across the obstetric unit. Include processes such as anesthesiology board sign-out at each shift change; pre-procedural timeouts; post-procedural debriefings, as indicated; and twice daily interdisciplinary rounds or huddles to discuss management plans for patients on labor and delivery, antepartum and postpartum units.

IX1C. Describe how the anesthesiology service evaluates: (1) patients admitted for scheduled cesarean delivery and other obstetric surgical procedures, and (2) the majority of patients admitted to the labor and delivery unit.
Additionally, outline the process for notifying the anesthesiology service of newly admitted high-risk obstetric patients who require anesthetic evaluation or consultation.

IXD. Outline how timeouts are performed prior to all anesthetic interventions.

IX 2 Personnel Responsiveness

IX2AB. Describe the 24/7 availability of in-house and/or on-call surgical services, including expected response times for general surgeons, gynecologic-oncology surgeons, and trauma surgeons, as applicable to your institution.

IX2B. Outline your protocol or pathway to activate the interventional radiology team.

IX2C. Outline the obstetric conditions and/or maternal vital sign parameters that trigger activation of the response team. Describe the communication process used to notify all team members and explain how attending anesthesiologists are incorporated into the response to obstetric emergencies, including obstetric hemorrhage, severe hypertension, and non-reassuring fetal heart rate patterns.

IX2D. Outline the availability and operational plan for an additional operating room, including dedicated nursing, surgical technician, obstetric, and anesthesiology personnel, to accommodate emergency obstetric procedures when all obstetric unit operating rooms are occupied.

IX 3 Higher Level of Care

IX3A. Outline the qualifications of nursing staff who provide post-anesthesia care in the obstetric unit and describe their competencies to recover surgical patients from neuraxial sedation and general anesthesia.

IX3B. Describe your Center/Institution's intensive care unit(s) available to receive obstetric patients (e.g. expertise, proximity to the obstetric unit and capacity).

IX3C. Describe your Center/Institution's ability to provide invasive monitoring and other advanced management techniques for high-risk patients on the obstetric unit, or in another unit, including arterial lines, central lines, cardiac output monitoring, and transthoracic/transesophageal echocardiography.
What can be accommodated in your obstetric unit? Describe what requires transfer to another unit? Describe what requires transfer to another hospital?

IX3D. Outline your management of patients who need vasoactive drug infusions, intensive care or cardiac care, and/or additional monitoring requirements (e.g. monitored bed, telemetry).

X Education

X 1 Learning

X1A. **Essential Element:** Provide evidence of ongoing participation in continuing medical education and professional practice improvement relevant to obstetric anesthesia for core obstetric anesthesia faculty, with over 80% target for attending specialists being SOAP members, with attendance at a SOAP conference or equivalent obstetric anesthesia-focused meeting at least every other year. Please provide examples of professional practice improvement or evidence-based updates to clinical practice.

X1B. If applicable, please outline efforts made to ensure continuing medical education for all non-core faculty who cover the obstetric anesthesia service. If not applicable, type N/A.

X1C. **Essential Element:** Outline your Center/Institution's simulation drills and training.

X1D. Describe simulation training scenarios, practices, and compliance with The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements for obstetric hemorrhage and severe hypertension/preeclampsia.

X1E. Provide the number and percentage of supervising attending anesthesiologists (who cover obstetric anesthesia call), obstetricians, nurses, and other personnel who have participated in obstetric simulation (or inter-professional team training) in the last 5 years, or if more frequent, please indicate if yearly.

Please indicate the number and describe.

X1F. Outline obstetric anesthesia-related staff meetings.

X2 Teaching

X2A. Outline your approach to educating nurses, obstetricians and other healthcare providers.

X2B. Outline your approach, if applicable, to teaching obstetric anesthesia to residents, fellows, CRNAs/CAAs, and/or SRNAs.

X2C. Outline your approach to educating pregnant women and people, support person. and families.

X3 Diversity, equity, and inclusion

X3A. **Essential Element:** Outline the initiatives that have been completed at your Center/Institution to better meet the needs of patients from the most prevalent racial and ethnic minority group(s) that your facility serves (e.g. implicit bias training of healthcare providers; provision of health educational resources for non-English speakers).

X3B. **Essential Element:** Describe efforts to promote diversity, equity and inclusion of your workforce (e.g., support pipeline programs for groups underrepresented in medicine; diversity, equity and inclusion hiring/promotion practices; microaggression and bystander response training; mentorship/sponsorship of individuals from groups underrepresented in medicine and female trainees and faculty).

XI Recommendations and Guidelines Implementation

XI 1 Practice Guidelines for Obstetric Anesthesia by the ASA Task Force on Obstetric Anesthesia and SOAP Consensus Statements

XI1A. **Essential Element:** Provide evidence demonstrating implementation of the 2016 Practice Guidelines for Obstetric Anesthesia by the ASA Task Force on Obstetric Anesthesia and the Consensus Statements published by SOAP since 2014.

Please select all key elements (these recommendations are not otherwise addressed in other areas of this application):

- ☐ No routine requirement for platelet count assessment prior to neuraxial block placement in healthy patients
- ☐ Appropriate liquid and diet restrictions: Intrapartum (allow clear liquids in uncomplicated patients); cesarean delivery (clear liquids up to 2 hours prior)
- ☐ Timing of neuraxial analgesia: Allow neuraxial analgesia in early labor (no specific cervical dilatation required)

XI 2 SOAP Consensus Statement on the Management of Cardiac Arrest in Pregnancy

XI2A. **Essential Element:** Provide evidence demonstrating implementation of the 2014 SOAP Consensus Statement on the Management of Cardiac Arrest in Pregnancy.

XI 3 National Partnership Maternal Safety Bundles

XI3A. **Essential Element:** Confirm that aspects of the following Maternal Safety Bundles have been implemented

Select the appropriate item(s) if indeed implemented

- ☐ Obstetric Hemorrhage
- ☐ Severe Hypertension in Pregnancy

- [ ] Maternal Venous Thromboembolism
- [ ] Cardiac Conditions in Obstetrical Care
- [ ] Care for Pregnant and Postpartum People with Substance Use Disorder

XI4 Examples of National Partnership Maternal Safety Bundles

XI4A. **Essential Element:** Provide examples demonstrating implementation of key aspects of National Partnership Maternal Safety Bundles.
Outline at least one example of an item that has been implemented to address each domain (Readiness, Recognition and Prevention, Response, and Reporting and System Learning) for the following:

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy

XI 5 SOAP Consensus Statement on Neuraxial Anesthesia in Obstetric Patients Receiving Thromboprophylaxis

XI5A. **Essential Element:** Outline your approach to coordinating care for patients receiving ante- and post-partum thromboprophylaxis as outlined by the 2018 SOAP Consensus Statement on Neuraxial Anesthesia in Obstetric Patients Receiving Thromboprophylaxis.
Describe a process by which obstetric anesthesia providers are informed about patients receiving thromboprophylaxis.

XI 6 SOAP Consensus Statement on Neuraxial Procedures in Obstetric Patients with Thrombocytopenia

XI6A. **Essential Element:** Outline your approach to providing neuraxial labor analgesia and anesthesia in patients with thrombocytopenia as outlined by the 2021 SOAP Consensus Statement on Neuraxial Procedures in Obstetric Patients with Thrombocytopenia.

XII Quality Assurance and Patient Follow-up

XII 1 Quality Assurance

XII1A. Describe how a supervising attending anesthesiologist serves as a member of the team that develops and implements multidisciplinary clinical policies (e.g. quality improvement committee, patient safety committee).

Outline current quality assurance and other patient care initiatives that the obstetric anesthesia division is leading, and/or involved in.

XII1B. Outline the involvement of obstetric anesthesia staff in hospital committees. Describe committees (e.g., peer review, blood management) that the obstetric anesthesia staff are involved in, and their role in these committees.

XII1C. Outline if a member of the obstetric anesthesiology team (e.g.,attending anesthesiologist) is an active participant in multidisciplinary root cause analysis, maternal case conferences, or equivalent program to evaluate maternal and/or fetal ad-verse events. Provide examples of effective implementation of identified system solutions.

XII 2 Follow-up of Patients

XII2A. **Essential Element:** Describe the follow-up patients receive after neuraxial analgesia, cesarean delivery anesthesia, or anesthesia for other procedures (e.g., postpartum tubal ligation, cerclage).
Are patients evaluated, and protocol criteria fulfilled prior to discharge or transfer from the obstetric unit? Are all patients who received an anesthetic or analgesic procedure seen by the obstetric anesthesia team on the postpartum unit prior to hospital discharge?

XII2B. Describe your Center/Institution's approach to routinely collecting patient feedback on maternal experience, with a specific focus on anesthetic and analgesic care.

Attachments

Send your attachments via email with your application to soap@soap.org. If your files are too large to send via email, request a Dropbox link from soap@soap.org. You are able to send as many attachments as you like but are required to submit the five attachments listed below.

Required Attachments:
Attachment 1 - Curriculum Vitae (CV) of the Lead Obstetric Anesthesia Attending (Faculty or Group Lead) (essential)
Attachment 2 - Quality Assurance Review for general anesthesia for cesarean delivery (essential)
Attachment 3 - Algorithm for Epidural top-ups for breakthrough pain during labor analgesia
Attachment 4 - Massive Transfusion Protocol (essential)
Attachment 5 - Postpartum Hemorrhage Protocol (essential)
Attachment 6 - Intraoperative pain during cesarean delivery (prevention, mitigation, treatment) protocols (essential)
Attachment 7 Post-cesarean opioid-sparing multimodal analgesia protocol (or order set) (essential)