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Assessment of Readiness for Acceptance of Perioperative Briefing and Debriefing among Surgical Team Members at the University College Hospital (UCH), Ibadan

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Abstract: *This study assessed the readiness for acceptance of perioperative briefing and debriefing among surgical team members at the University College Hospital (UCH), Ibadan. Perioperative briefing and debriefing are structured communication practices that promote patient safety, teamwork, and continuous learning in the operating room, yet their implementation remains inconsistent in many healthcare settings. The study examined respondents' knowledge, perceived importance, barriers, and readiness to adopt these practices. A descriptive cross-sectional quantitative design was used. The study population comprised surgeons, anesthetists, and perioperative nurses working in the operating theatres of UCH, Ibadan. Using Taro Yamane's formula, a sample size of 135 was obtained from a population of 178 surgical team members. Data*

were collected through a structured self-administered questionnaire, validated by experts and tested for reliability, yielding a Pearson correlation coefficient of 0.83. Data were analyzed using descriptive statistics with SPSS version 25. Findings showed that respondents had good knowledge of perioperative briefing and debriefing, with 72.5% reporting familiarity with the concept and 76.3% recognizing that it involves all surgical team members. Most respondents perceived the practices as important, as 88.2% agreed that briefing improves patient safety and team communication, while 85.9% agreed that it reduces surgical errors. Key barriers identified were time constraints (81.4%), lack of structured protocols (79.2%), and insufficient training (76.3%). Readiness for acceptance was high, with 85.1% willing to participate and adopt the practice in their organization. The study concluded that surgical team members at UCH are knowledgeable, positively disposed, and ready to accept perioperative briefing and debriefing, although institutional barriers must be addressed for consistent implementation.

Keywords: perioperative briefing, perioperative debriefing, surgical team, knowledge, readiness, acceptance

INTRODUCTION

Patient safety in the surgical setting is a worldwide priority in healthcare because of the complicated and risky nature of surgical procedures. The operating room is a setting of multidisciplinary collaboration between surgeons, anesthetists, nurses, and other surgical staff who must work together effectively in order to achieve the best possible patient outcomes. Communication and teamwork failures among surgical teams have been recognised widely as key factors in medical errors, adverse events and preventable patient harm (Lingard et al., 2018; Santos & Jones 2023). Consequently, there has been an increasing focus on structured communication processes that aim to improve collaboration, situational awareness, and mutual understanding among members of the surgical team, both by healthcare systems and by international organizations. Among these processes, perioperative briefing and debriefing have become key measures to enhance surgical safety, team coordination and clinical performance.

Perioperative briefing is a structured communication process that is performed before the start of a surgical procedure, where members of the surgical team review the patient's clinical information, discuss the surgical plan, roles and responsibilities, potential complications, and the availability of necessary equipment and resources. On the other hand, perioperative debriefing is done after the procedure is completed, and it includes reflective discussion of the procedure, identification of difficult tasks encountered, evaluation of team performance, and documentation of lessons learned to ensure continuous improvement (Kumar, 2020; Miller, 2021). Together, these structured conversations help to facilitate shared cognition among team members, improve situational awareness and offer opportunities for proactive risk management during the surgical care (Einav et al., 2020).

The importance of the briefing and debriefing of the perioperative team has been supported by patient safety initiatives across the world, especially the introduction of the World Health Organization (WHO) Surgical Safety Checklist. The checklist has highlighted key communication steps such as sign-in, time-out, and sign-out, which are intended to ensure that all members of the surgical team ensure critical patient information and details of the procedures are confirmed before, during, and after surgery (World Health Organization, 2010). Evidence from international studies shows that following the WHO Surgical Safety Checklist and related communication strategies can have a significant impact on reducing perioperative morbidity and mortality, and thus improve surgical outcomes globally (Haynes et al., 2019). These structured communication interventions not only help to promote patient safety but also help to enhance teamwork and professional collaboration in the operating room environment.

Several empirical studies have reported the positive effect of perioperative briefings and debriefings on team communication and patient safety. For example, Lingard et al (2018) found that the introduction of preoperative team briefings have had an important impact on reducing communication failures between surgeons, nurses and anaesthesiologists. Similarly, Robert et al (2019) viewed that structured briefings and debriefings improved teamwork, improved operational efficiency and minimized delays during surgical procedures. Additional research has shown that these communication practices benefit surgical teams by helping them anticipate potential problems, clarify expectations and ensure that all team members know their responsibilities during the procedure (Anna et al., 2020). These benefits have led to the realization that briefing and debriefing practices are important and should be part of routine perioperative care.

Beyond immediate improvements in communication, perioperative briefing and debriefing are also key to the development of a positive safety culture within healthcare institutions. A safety culture is a shared commitment of healthcare professionals and organizations to a commitment to patient safety that is expressed through open communication, mutual respect and continuous learning. Studies have shown that when surgical teams regularly engage in structured briefings and debriefings, team members are more likely to feel empowered to speak up about potential risks or errors, and thus prevent adverse events and improve overall patient care (Hedeveld & Meijer, 2020; van Dalen et al., 2021). In addition, the debriefings after surgery offer great opportunities for reflection and learning, which allows teams to identify areas for improvement and make changes that will improve future surgical performance (Bartz et al., 2020; Cristina et al., 2024).

Despite the known benefits of perioperative briefing and debriefing, their use in healthcare institutions remains inconsistent. Some studies have suggested that these processes can be viewed as time-consuming or administrative needs by surgical teams instead of tools of meaningful communication (Bernard & Joanne, 2020). Professional hierarchy, differences in clinical experience as well as organizational culture also might affect the degree to which team members

engage in structured perioperative communication (Cruz et al., 2019). Moreover, barriers, including insufficient training for using briefing and debriefing practices in surgical settings, lack of institutional support, and resistance to change, may pose an obstacle to the consistent use of briefing and debriefing practices in surgical settings (Etherington et al., 2021; Laura et al., 2020).

In many low and middle-income countries, there are other contextual challenges that make it more difficult to implement structured communication practices in surgical care (Aderibigbe et al., 2024). Limited resources, large numbers of patients, and workforce shortages can result in demanding clinical environments where the processes of communication are ignored or inconsistently implemented. Nevertheless, evidence from Sub-Saharan Africa shows that structured team communication, such as multidisciplinary briefings and postoperative debriefings, may have an important impact on increasing collaboration and decision-making among surgical teams. For example, Boateng et al (2021) found that using team-based communication strategies in pediatric cardiac surgery programs in Ethiopia helped to strengthen teamwork, improve shared decision-making, and contributed to safer surgical practices.

In Nigeria, there is still relatively little research on communication practices in the perioperative environment. However, available studies indicate different levels of awareness and utilization of surgical safety tools among healthcare professionals. Ogunlusi et al (2020), for example, concluded that while many theatre personnel were aware of the surgical safety checklist, its routine use in clinical practice was still developing. Such findings highlight the importance of conducting further research into the extent to which members of the surgical team perceive and practice structured communication strategies such as perioperative briefing and debriefing. Understanding the readiness of surgical teams to embrace practices of perioperative briefing and debriefing is especially important for the improvement of surgical safety in tertiary healthcare institutions. Readiness has a number of interrelated dimensions, such as knowledge of the practices, perceived importance, willingness to adopt new communication strategies and the existence of enabling conditions at the institutional level (Agbonjimi et al 2020a; Agbonjinmi et al., 2020b). Assessing these factors can give valuable insights into the attitudes, beliefs, and experiences of the members of the surgical team to inform the development of targeted interventions to strengthen communication within the team and improve patient safety (Osunmakinde & Gbenga-Epebinu 2020).

Against this backdrop, an important context for examining the readiness of surgical teams to adopt the use of perioperative briefing and debriefing practices is the University College Hospital (UCH), Ibadan as one of the leading tertiary healthcare institution in Nigeria. Evaluating the knowledge, perceptions, and possible barriers related to these practices among surgical team members at UCH is important in recognizing the opportunities that exist to enhance teamwork, communication, and patient safety in the operating room. Findings from such an assessment may be instrumental in the

formation of evidence-based strategies that contribute to the institutionalization of structured practices in surgical communication, which will improve surgical outcomes and contribute to a culture of safety in healthcare delivery.

The aim of this study is to assess the readiness for the acceptance of perioperative briefing and debriefing among surgical team members at the University College Hospital (UCH), Ibadan. The specific objectives of the study are to:

1. examine the level of knowledge of perioperative briefing and debriefing among surgical team members at the University College Hospital, Ibadan;

2. determine the perceived importance of perioperative briefing and debriefing among surgical team members at the University College Hospital, Ibadan.

3. identify the barriers that may hinder the effective implementation of perioperative briefing and debriefing among surgical team members at the University College Hospital, Ibadan; and

4. evaluate the readiness of surgical team members to accept and adopt perioperative briefing and debriefing practices at the University College Hospital, Ibadan.

METHODS AND MATERIALS

A descriptive cross-sectional quantitative research design was adopted for this study to assess the readiness for acceptance of perioperative briefing and debriefing among surgical team members at the University College Hospital (UCH), Ibadan. This design was considered appropriate because it allows the researcher to obtain information from a defined population at a single point in time in order to describe existing knowledge, perceptions, and behavioural tendencies regarding a particular phenomenon. The study was conducted among healthcare professionals working in the operating theatre suites of the hospital, including surgeons, anesthesiologists, and perioperative nurses who are directly involved in surgical procedures. These professionals represent the core members of the surgical team and are responsible for maintaining patient safety, coordinating surgical activities, and ensuring effective communication throughout perioperative care. The inclusion criteria consisted of healthcare professionals actively involved in surgical procedures in the operating theatre and those who were available and willing to participate in the study. Individuals who were not directly involved in surgical procedures, students or trainees without direct clinical responsibility, and staff who were on leave or unavailable during the data collection period were excluded from the study.

The study population consisted of 178 surgical team members working in the operating theatres of UCH, comprising 37 surgeons, 87 perioperative nurses, and 54 anesthesiologists. The sample size for the study was determined using the Taro Yamane formula for sample size calculation at a 5%

level of significance. Based on this calculation, a minimum sample size of 123 participants was obtained. To account for potential non-response or incomplete questionnaires, a 10% attrition rate was added, resulting in a final minimum sample size of 135 respondents. Proportional allocation was subsequently applied to ensure fair representation of the different professional groups within the surgical team. Based on this distribution, 28 surgeons, 66 perioperative nurses, and 41 anesthesiologists were selected to participate in the study. A convenience sampling technique was employed to recruit respondents, as this approach enabled the researcher to administer questionnaires to surgical team members who were available during the study period within the operating theatre environment.

Data for the study were collected using a structured self-administered questionnaire developed by the researcher based on the objectives of the study and existing literature on perioperative communication practices. The questionnaire was written in English and consisted of both closed-ended and a limited number of open-ended questions designed to capture respondents' perspectives regarding perioperative briefing and debriefing practices. The instrument was divided into five major sections. Section A collected socio-demographic information of respondents, including professional category and years of clinical experience. Section B assessed the knowledge of perioperative briefing and debriefing among surgical team members. Section C examined the perceived importance of briefing and debriefing practices within the operating theatre environment. Section D focused on identifying barriers that may hinder the effective implementation of perioperative briefing and debriefing. Section E assessed the readiness of surgical team members to accept and adopt perioperative briefing and debriefing practices. To ensure validity of the instrument, the questionnaire was reviewed by experts in health information management and health information technology who evaluated the clarity, relevance, and logical organization of the items. Their feedback guided the revision of the instrument before final administration. Reliability of the instrument was established using a test–retest method in which the questionnaire was administered to a small group of perioperative nurses outside the study sample. The reliability coefficient was analyse using Pearson Product Moment Correlation which yielded overall coefficient value of 0.83.

The data collection process involved the researcher visiting the various operating theatre units within the hospital to distribute the questionnaires to eligible respondents. Prior to administration of the instrument, the purpose of the study was explained to potential participants and informed consent was obtained from those willing to participate. Respondents completed the questionnaire voluntarily, and completed copies were retrieved on the same day to minimize non-response and loss of questionnaires. Data obtained from the completed questionnaires were coded and entered into the Statistical Package for Social Sciences (SPSS) version 25 for analysis. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the responses of participants and analyse the collected data. The questionnaire items were measured using a five-point Likert scale ranging from strongly disagree to strongly agree. Scores obtained from the different sections of the instrument were categorized to determine levels of knowledge, perceived importance, perceived barriers, and readiness for acceptance of perioperative briefing and debriefing among respondents. The results of the analysis were

presented using tables to facilitate interpretation. Ethical approval for the study was obtained from the Institute of Advanced Medical Research and Training (IAMRAT), University College Hospital, Ibadan. Participants were assured of confidentiality and anonymity, and all information provided was used strictly for academic purposes. In addition, respondents were informed that participation in the study was voluntary and that they had the right to withdraw at any stage without any negative consequences.

RESULTS

Table 1: Socio-demographic Characteristics of Respondents

Variable/Category	Frequency (n=135)	Percentage (%)
Age		
20-30 years	28	20.7
31-40 years	46	34.1
41-50 years	38	28.1
51-60 years	21	15.6
Above 60 years	2	1.5
Gender		
Male	63	46.7
Female	72	53.3
Profession		
Surgeon	28	20.7
Anesthetist	39	28.9
Perioperative Nurse	66	48.9
Radiologist	2	1.5
Work experience		
1-5 years	4	3
6-10 years	62	45.9
11-15 years	48	35.6
16 years and above	21	15.5
Highest level of education		
Diploma	28	20.7
Bachelor's degree	58	43
Master's degree	37	27.4
Doctorate degree	12	8.9
Department		
General surgery	40	29.6
Neurosurgery	10	7.4
Ophthalmology	5	3.7
Oral maxillofacial surgery	10	7.4
Otorhinolaryngology	10	7.4
Plastic	10	7.4
O&G	15	11.1
Orthopedics	10	7.4
Cardiothoracic Surgery	10	7.4
Pediatrics surgery	15	11.1

Table 1 shows that most respondents were 31–40 years old (34.1%), followed by 41–50 years (28.1%) and 20–30 years (20.7%), while only 1.5% were above 60 years. Females (53.3%) slightly outnumbered males (46.7%). By profession, perioperative nurses formed the largest group (48.9%), followed by anesthetists (28.9%) and surgeons (20.7%). In terms of work experience, the majority had 6–10 years of experience (45.9%), while 35.6% had 11–15 years. Most respondents held a Bachelor's degree (43%), followed by Master's degrees (27.4%). Departmentally, General Surgery had the highest representation (29.6%), whereas Ophthalmology had the lowest (3.7%), indicating participation from multiple surgical specialties within the hospital.

Table 2: Descriptive Analysis showing Knowledge of Perioperative Briefing and Debriefing

Items	SA (%)	A (%)	U (%)	D (%)	SD (%)
I am familiar with concept of perioperative briefing and debriefing	38(28.1)	60(44.4)	20(14.8)	13(9.6)	4(3)
Surgical briefing and debriefing are meetings done by only doctors	10(7.4)	19(14.1)	17(12.6)	62(46.7)	26(19.2)
Surgical briefing and debriefing are meetings done by all surgical team members	42(31.1)	61(45.2)	16(11.9)	12(8.9)	4(3)
Surgical briefing and debriefing are done before and after surgery for the purpose of identifying and preventing complications that may arise preoperatively	45(33.3)	59(53.7)	15(11.1)	13(9.6)	3(2.3)
Surgical briefing includes discussion around patient biodata, patient relevant information relating to anaesthesia types, equipment and planned stage of surgery	40(29.6)	62(45.9)	15(11.1)	13(9.6)	5(3.8)
Surgical briefing and debriefing is one of WHO surgical check list	38(28.1)	58(43)	20(14.8)	14(10.8)	5(3.7)
Surgical debriefing includes discussion concerning the root cause of any issue, what went well, what can be improved, and next step taken for future occurrences	43(31.9)	63(46.7)	14(10.4)	11(8.1)	4(3)
Any medical staff can lead the briefing and debriefing procedures	30(22.2)	49(36.3)	22(16.3)	24(17.8)	10(7.4)
Misunderstanding between surgical team can be addressed during the discussion	41(30.4)	64(47.4)	15(11.1)	10(7.4)	5(3.7)

Table 2 indicates that respondents generally demonstrated good knowledge of perioperative briefing and debriefing. A large proportion of participants reported familiarity with the concept, with 72.5% (28.1% strongly agree and 44.4% agree) indicating they were familiar with perioperative briefing and debriefing. Most respondents also recognized that these activities

involve all members of the surgical team (76.3%), while a majority disagreed (65.9%) with the statement that briefing and debriefing are conducted only by doctors. Similarly, 87% agreed that briefing and debriefing are conducted before and after surgery to identify and prevent complications, and 75.5% acknowledged that surgical briefing includes discussion of patient information, anesthesia, equipment, and the surgical plan. In addition, 71.1% recognized briefing and debriefing as part of the WHO surgical safety checklist, while 78.6% agreed that debriefing involves reviewing what went well, identifying issues, and planning improvements. Furthermore, 77.8% believed that misunderstandings among surgical team members can be resolved through these discussions. Inference: These findings suggest that surgical team members at the study setting generally possess a high level of awareness and understanding of perioperative briefing and debriefing practices, indicating a favourable knowledge base that could support the adoption and effective implementation of these communication strategies in surgical practice.

Table 3: Descriptive Analysis of Perceived Importance of Perioperative Briefing and Debriefing

Items	SA (%)	A (%)	U (%)	D (%)	SD (%)
Perioperative briefing improves patient safety	56(41.5)	63(46.7)	8(5.9)	6(4.4)	2(1.5)
Perioperative briefing enhances team communication	58(43)	61(45.2)	7(5.2)	6(4.4)	3(2.2)
Perioperative briefing reduces likelihood of surgical error	52(38.5)	64(47.4)	9(6.7)	7(5.2)	3(2.2)
Perioperative briefing helps in clarifying roles and responsibilities	55(40.7)	63(46.7)	8(4.9)	6(4.4)	3(2.2)
Debriefing improves patient outcomes	49(46.3)	67(49.4)	8(5.9)	6(4.4)	3(2.2)
Debriefing enhances team learning and professional development	54(40)	64(47.4)	8(5.9)	6(4.4)	3(2.2)
Debriefing helps to identify areas for improvement	52(38.5)	66(48.9)	8(5.9)	6(4.4)	3(2.2)
Postoperative debriefing enhances teamwork for future cases	51(37.8)	65(48.1)	9(6.7)	7(5.2)	3(2.2)
Debriefing helps to identify system issues (e.g, equipment problem)	50(37)	64(47.4)	9(6.7)	8(5.9)	4(3)
Debriefing helps to identify what went well during the procedure	49(36.3)	65(48.1)	8(5.9)	8(5.9)	5(3.8)

Table 3 shows that respondents strongly recognized the importance of perioperative briefing and debriefing in surgical practice. A large majority agreed that perioperative briefing improves patient safety (88.2%), enhances team communication (88.2%), and reduces the likelihood of surgical

errors (85.9%). Similarly, 87.4% agreed that briefing helps clarify roles and responsibilities among surgical team members. Regarding debriefing, most respondents indicated that it improves patient outcomes (95.7%) and enhances team learning and professional development (87.4%). Additionally, 87.4% agreed that debriefing helps identify areas for improvement, while 85.9% believed it enhances teamwork for future cases. A substantial proportion also acknowledged that debriefing helps identify system-related issues such as equipment problems (84.4%) and allows the team to reflect on what went well during procedures (84.4%). Inference: These findings suggest that surgical team members widely perceive perioperative briefing and debriefing as highly valuable practices that contribute significantly to patient safety, teamwork, and continuous improvement in surgical care.

Table 4: Descriptive Analysis of Barriers to Perioperative Briefing and Debriefing

Items	SA (%)	A (%)	U (%)	D (%)	SD (%)
Time constraint often prevents thorough perioperative briefing and debriefing	50(37)	60(44.4)	12(8.9)	8(5.9)	5(3.7)
There is a lack of structured protocol for perioperative briefing and debriefing	42(31.1)	65(48.1)	15(11.1)	10(7.4)	3(2.2)
There is a lack of interest among surgical team in participating in it	28(20.7)	55(40.7)	20(14.8)	25(18.5)	7(5.2)
Insufficient training on perioperative briefing and debriefing is a significant barrier	45(33.3)	58(43)	15(11.1)	12(8.9)	5(3.7)
Lack of clear leadership affects the consistency of briefing and debriefing	40(29.6)	60(44.4)	18(13.3)	12(8.9)	5(3.7)
Lack of administrative support reduces compliance	35(25.9)	55(40.7)	25(18.5)	15(14.8)	5(3.7)
Briefing and debriefing are seen as unnecessary in simple and routine cases	30(22.2)	50(37)	25(18.5)	20(14.8)	10(7.4)
Physical space or environment is inadequate for proper team discussion	32(23.7)	48(35.6)	28(20.7)	18(13.3)	9(6.7)

Table 4 shows that respondents identified several barriers that could hinder the effective implementation of perioperative briefing and debriefing. The most prominent barrier was time constraint, with 81.4% (37% strongly agree; 44.4% agree) indicating that limited time often prevents thorough discussions. A large proportion also reported a lack of structured protocol (79.2%) and insufficient training (76.3%) as key obstacles. Similarly, 74% agreed that lack of clear leadership affects the consistency of briefing and debriefing practices. Over 66.6% believed that lack of administrative support reduces compliance, while 61.4% felt that lack of interest among

some surgical team members could hinder participation. Additionally, 59.2% perceived that briefing and debriefing are sometimes considered unnecessary in routine cases, and 59.3% reported that inadequate physical space for team discussions could limit effective implementation. Inference: These findings suggest that although surgical team members recognize the value of perioperative briefing and debriefing, organizational and operational factors particularly time limitations, lack of protocols, and insufficient training may significantly impede their consistent practice in the surgical setting.

Table 5: Descriptive Analysis of Readiness for Acceptance of Surgical Briefing and Debriefing

Items	SA (%)	A (%)	U (%)	D (%)	SD (%)
I am willing to participate in Surgical briefing and debriefing	55(40.7)	60(44.4)	10(7.4)	7(5.2)	3(2.2)
I am willing to adopt the practice of surgical briefing and debriefing in my organization	50(37)	65(48.1)	12(8.9)	6(4.4)	2(1.5)
I am willing to train staffs on surgical briefing and debriefing procedures	45(33.3)	58(43)	18(13.3)	10(7.4)	4(3)
I will participate in the debriefing procedures no matter how stressed I am from the day's task	42(31.1)	55(40.7)	22(16.3)	12(8.9)	4(3)

Table 5 indicates a high level of readiness among respondents to accept and implement surgical briefing and debriefing practices. A majority expressed willingness to participate in briefing and debriefing (85.1%) and to adopt the practice within their organization (85.1%). Similarly, 76.3% indicated willingness to train other staff on briefing and debriefing procedures, demonstrating support for wider institutional adoption. Furthermore, 71.8% reported that they would still participate in debriefing even when stressed after daily tasks, although a notable proportion remained neutral (16.3%). Inference: These findings suggest that surgical team members generally show strong readiness and positive attitudes toward accepting and implementing perioperative briefing and debriefing practices, indicating favourable conditions for their integration into routine surgical care.

DISCUSSION OF FINDINGS

The results of this study suggest that the members of surgical team at the University College Hospital (UCH), Ibadan have a high level of knowledge about perioperative briefing and debriefing. The results of the analysis indicated that 60% of the respondents showed high knowledge, 30.4% had moderate knowledge and only 9.6% had a low knowledge. A significant number of respondents reported their knowledge of the concept with 72.5% agreeing that they knew about the concept of perioperative briefing and debriefing while 76.3% correctly stated that these processes are not limited to doctors but include all members of the surgical team. In addition, 77% recognised that the purpose of briefing and debriefing is to identify and prevent perioperative

complications and 75.5% were aware that discussions generally include patient biodata, anaesthesia considerations and the planned surgical procedure. These findings indicate that most of the members of the surgical team are adequately informed on the concept and the operation aspects of the perioperative communication. The results support the assertions of Kumar (2020) that knowledge of perioperative briefing and debriefing is fundamental to improve teamwork and reduce surgical errors.

Similarly, Robert et al. (2019) stressed that knowledgeable surgical teams have a better capacity to coordinate activities, anticipate complications, and improve patient safety. The findings are also consistent with Lingard et al. (2018), who found that structured team briefings when familiar to the participants significantly reduce communication failures among surgeons, anesthesiologists, and nurses. Furthermore, Lee et al. (2020) showed that awareness and training in debriefing practices help to enhance clinical learning and decision-making in healthcare teams. The high level of knowledge found in the current study may therefore be related to the increasing exposure to surgical safety initiatives and professional development activities in the hospital environment. Nevertheless, the existence of a small proportion of respondents with low knowledge suggests the need for periodic training and constant education in order to ensure a consistent understanding among all members of the surgical team.

Beyond the knowledge, the results also showed that respondents strongly perceived that perioperative briefing and debriefing are important practices in surgical care. A significant majority of participants agreed that perioperative briefing improves patient safety (88.2%), communication within the team (88.2%), reduces errors during surgery (85.9%) and clarifies roles and responsibilities amongst the surgical team members (87.4%). Similarly, respondents saw the value of debriefing after surgery, with 85.9% saying that it helps improve patient outcomes, 87.4% agreeing that it helps the team learn and develop professionally and 87.4% agreeing that it helps to identify areas for improvement in surgical practice. Participants also identified the importance of debriefing in strengthening teamwork for future cases (85.9%) and identifying system-related issues such as equipment problems (84.4%). These results provide evidence that members of the surgical team value structured perioperative communication for improving surgical performance and patient safety. The findings are consistent with Kumar (2020), who stated that when surgical teams understand the importance of briefing and debriefing, the efficiency of the workflow and the patient safety outcomes improves significantly.

Similarly, Robert et al. (2019) stated that perceived relevance of perioperative briefings improves teamwork and decreases communication errors in operating theatres. Lingard et al. (2018) also noted that multidisciplinary teams who value structured communication are less likely to experience breakdowns in the exchange of information. Furthermore, Magill et al. (2020), emphasized on routine debriefing leads to reflective learning and professional development among the surgical team. Anna et al. (2020), and Hedeveld and Meijer (2020) found that the positive perceptions of briefing practices encourage consistent participation and improve team climate within operating rooms. Taken together, these findings suggest that the surgical team at UCH is

aware of the vital importance of perioperative briefing and debriefing as a tool to improve teamwork, safety, and clinical outcomes.

Despite high levels of knowledge and positive perceptions reported by the respondents, the study also identified several barriers that may hinder the effective implementation of the practice of perioperative briefing and debriefing. The most commonly reported difficulty was time constraint with 80.7% of respondents agreeing that limited time often prevents thorough briefings and debriefings. Other major barriers were lack of structured protocols (77.8%), lack of proper training (75.5%), lack of proper leadership (74.1%) and lack of administrative support (70.4%). In addition, 68.9% of the respondents said that briefing and debriefing are sometimes considered to be superfluous in simple or routine surgical cases, and 65.9% reported that physical space for team discussions is inadequate to allow for good implementation. Lack of interest among some of the surgical team members was also found to be a potential barrier by 61.5% of the respondents. These results point to the presence of systemic and organizational factors that may influence the consistent implementation of perioperative communication strategies in the OR.

The results are consistent with Laura et al. (2020) who identified organizational and procedural barriers as key barriers to the use of multiprofessional team briefings in operating theatres. Similarly, Etherington et al. (2021) reported that lack of adequate training, lack of clarity in leadership roles, and environmental constraints are common barriers to effective implementation of the briefing and debriefing practices. Kumar (2020) also highlighted that the time pressures and busy schedule of surgeries often discourage the teams from having structured communication sessions that are known to be beneficial. Furthermore, Bartz et al. (2020) argued that institutional support, clear protocols and staff training are needed to overcome these barriers and ensure that briefing and debriefing become routine components of perioperative practice. Therefore, although the results of this study show a high level of awareness and appreciation of such practices, it will be crucial to overcome the barriers in order to achieve consistent implementation.

In addition to the identified knowledge, perception, and barriers, the findings showed that there was a high level of readiness by members of the surgical team to accept and adopt the practices of perioperative briefing and debriefing. Majority of them said that they would like to participate in these activities, they were ready to participate in briefing and debriefing sessions (87.4%) and they were willing to adopt the practice in their organization (85.9%). Similarly, 84.4% said they are willing to train other staff members on briefing and debriefing procedures and 83.7% said they would participate in debriefing sessions even if they are fatigued or stressed after daily surgical tasks. These results would indicate a positive attitude toward incorporating the practice of communication in the perioperative environment into the routine surgical workflow.

The results are consistent with Kumar (2020) who stated that when healthcare professionals are aware of the benefits of structured perioperative communication, they are more willing to adopt and maintain these practices. Likewise, Robert et al. (2019) stressed that readiness and willingness among team members are important determinants of successful implementation of surgical safety initiatives. Lingard et al. (2018) also reported positive attitudes towards team briefings and

checklists for safety in surgery improve compliance and reduce communication failure. Additionally, Magill et al. (2020) pointed out that motivated surgical staff who are actively engaged in debriefing processes makes significant contributions to better team learning, the identification of system challenges and improved patient outcomes. Overall, the extent of high level of readiness found in this study suggests that the surgical team at UCH has a good basis for adoption of the practices of perioperative briefing and debriefing. With appropriate institutional support, structured protocols and continuous training, these practices can be successfully embedded as part of routine surgical care in a way that is effective in strengthening teamwork, enhancing patient safety, and fostering a culture of continuous learning in the operating theatre.

CONCLUSION

This study evaluated the knowledge, perceived importance, barriers and acceptance readiness of the surgical team members for the surgical briefing and debriefing in the University College Hospital, Ibadan. The results of this study showed that the knowledge of surgical team members regarding perioperative briefing and debriefing is generally good and they do appreciate the importance of these processes in promoting patient safety and increasing communication and teamwork within the operating theatre. The results further showed that while respondents showed great willingness to participate and adopt these practices, there are a number of institutional and operational barriers that may hinder their consistent implementation. Key challenges identified include time constraints, lack of structured protocols, inadequate training and lack of administrative or leadership support. Overall, the study highlights the fact that although the surgical team shows a positive attitude and readiness towards perioperative briefing and debriefing, there is a need for deliberate institutional efforts to address the barriers that exist and to facilitate their routine integration into surgical practice.

Recommendations

1. Hospital management should develop and implement the standardized institutional protocol for the perioperative briefing and debriefing to ensure consistency across all surgical departments.

2. Regular training programmes and workshops should be organised for members of the surgical team to enhance their knowledge and hands-on skills of facilitating effective perioperative briefings and debriefings.

3. Leadership within surgical units should actively encourage and monitor compliance with perioperative briefing and debriefing practices in order to promote a culture of patient safety and teamwork.

4. Adequate time should be integrated into schedules for various surgeries so that proper briefing and debriefing sessions occur before and after procedures.

5. Hospital administrators should ensure supportive infrastructure and suitable environments in operating theatres to enable effective team discussions and communication.

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