Four Plan-Do-See-Act (PDSA) cycles (see Table 1) were used to:

1. Quantify the number of specimen errors related to mislabelling;
2. Understand the current-state process for collecting specimens in the endoscopy clinic (Figure 1);
3. Understand the impact of mislabelling errors in the pathology department; and
4. Develop change ideas based on best practices and trial the proposed process (Figure 2) during a one-week pilot in May 2019.

**Aim**

To reduce the incidence of mislabelled specimens collected in the endoscopy clinic.

**Actions Taken**

Changes trialled during the pilot:

- Transferring specimens directly into containers so they can be labelled as they are collected.
- Assigning all specimen-related tasks to the primary nurse to reduce miscommunication errors during hand-offs.
- Requiring sign-off from the physician and primary nurse so specimen documentation requires a two-step verification process.

**Summary of Results**

Pilot observations identified challenges with transferring specimens directly into containers and assigning all specimen-related tasks to the primary nurse. The dual sign-off yielded no major concerns.

Next steps include reviewing techniques used to transfer specimens into containers and investigating options to support the primary nurse in completing all specimen-related tasks.