A prospective study of CPG implementation for treatment in adult in-patients who had DFIs was conducted at surgical and orthopedics wards. The CPG was developed by the investigator team based on the data from our previous study (submitted to publish). CPG was presented monthly to train the orthopedic and vascular surgeons for 1 year. The empirical ATB regimens were prescribed by the responsible surgeon who was trained to use CPG. Demographics data, wound characteristics, microbiological data, ATB therapy, and clinical outcome were recorded. The appropriate empirical ATB treatment was determined by investigators weather CPG matched or microbiological matched. The adherence to CPG, the appropriate empirical ATB, and the unfavorable outcomes were analyzed. All findings were reported by descriptive and inferential statistics.

**Results.** A total of 85 DFIs patients were enrolled. The patients received the appropriate empirical ATB matched to CPG and matched to microbiological data, were 87% and 67%, respectively. The unfavorable outcome was 26% while previously it was 72.4% (submitted to publish data) before CPG implementation. The independent factors associated with unfavorable outcomes were (1) inappropriate ATB and (2) infections with drug resistant pathogens (adjusted relative ratio: aRR 2.98; 95% CI: 1.36–6.55, P = 0.007 and aRR 1.90; 95% CI: 1.05–3.43, P = 0.034, respectively).

**Conclusion.** The current study demonstrated that monthly training of CPG can enhance in the high adherence (87%) of CPG use and resulting in high rate of appropriate empirical ATB. Educational intervention insisted the responsible physician for administration the appropriate ATB with the treatment of unfavorable outcome in DFIs.

**Disclosures.** All authors: No reported disclosures.

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**1310. Improving Infectious Disease Electronic Medical Records Documentation: A Quality Improvement Study in an Academic Teaching Hospital**

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**Background.** Improving efficiency of documentation and sign outs during transitions of care were identified as areas of interest by the Society of South Florida Infectious Disease (ID) Division. Our aim is by May 2018, we will achieve >50% improvements in our ID EMR note efficiency score for any adult patient at Tampa General Hospital. Note efficiency score involves listing all of the key elements with 1 point awarded for each: active problem in the subjective, updated hospital course under assessment, active problem prioritized first under assessment and non-relevant problems removed from assessment.

**Methods.** Institute of Healthcare Improvement's model with Plan-Do-Study-Act (PDSA) cycles was used for project implementation from March 2018 to May 2018 (Figure 1). Cycle 1: Conducting a needs assessment survey and education. Cycle 2: Changing the existing template and implementing a new standardized template that includes the key elements, along with removal of auto populated non-relevant information. Audits of notes with a ≥4-point system scoring was done. A pre and post implementation physician survey was conducted.

**Results.** DFID and faculty completed the baseline survey (N = 25). Less than half (40%) that they could interpret the note easily. Fewer respondents (36%) felt there was adequate weekend sign out. More than one-third (36%) reported writing majority of notes after 5 pm (Figure 1). Pilot project involved nine ID faculty and fellows. We had 95% compliance with use of the standardized EMR template. Notes were evaluated at baseline (n = 190), midway through cycle 1 (n = 42) and cycle 2 (n = 190). An increase in average note efficiency score from baseline, cycle 1 and cycle 2 occurred as follows (Mean ± SD): 2.0 ± 0.84 vs. 2.8 ± 0.95 vs. 3.6 ± 0.5 (Figure 2). Compared with baseline, cycle 2 achieved 42% improvement in the ease of interpretation of patient assessments and 41% improvement in adequate sign out. No increase in note writing after 5pm (36% vs. 30% baseline and cycle 2, respectively) reported.

**Conclusion.** Targeted education and changing the EMR note template can achieve improved efficiency of ID note. These efforts to improve documentation enhance physician's ease of interpretation of patient assessments and sign out during transition of care.