Higher Learning Lab · Free research resource · CC BY-NC 4.0

Style Guide for Better Trauma-Informed Documentation

Bjorn, Genevive (Higher Learning Lab)

Published 2025-11-30 by Higher Learning Lab, a 501(c)(3) nonprofit, Dover, Delaware.

Canonical version: https://www.higherlearninglab.org/portfolio/style-guide-for-better-trauma-informed-documentation/

Licensed under Creative Commons Attribution-NonCommercial 4.0.

By Higher Learning Lab

Citation: Bjorn, G. (2025). *Style guide for better trauma-informed documentation*. Higher Learning Lab. https://doi.org/10.5281/zenodo.23541092

1. Style Guide Purpose

This style guide add-on standardizes documentation practices to promote clarity, safety, and trauma-informed care. It serves as an add-on to any existing documentation standard.

2. Style Guide Core Principles

- Safety and predictability
- Neutral, observable, non-pathologizing language
- Minimize retelling and duplication
- Maintain client agency, choice, and consent
- Ensure specificity, clarity, and traceability

3. Language Standards

- Use active verbs of report (stated, observed, noted) and avoid interpretation unless labeled.
- Avoid passive voice (e.g., “was observed”).
- Avoid judgmental terms (noncompliant, manipulative).
- Document behavior rather than inferred motives.

4. Template Elements

All add-ons for templates must include:

- Client Goals section at the top
- Micro-consent toggles
- “Why we ask” explanations
- Retelling-protection field referencing prior documents
- Separate fields for Client Voice, Practitioner Observation, Action Taken, Next Steps

5. Style Guide for Intake Forms

Style guide required elements:

- Completion-time estimate

- “You may skip any question” assurance
- Sensitive-section intro
- Optional retelling field

6. Style Guide for Case Notes

Style guide structure:

1. Context
2. Client Voice
3. Practitioner Observation
4. Actions + Choices Offered
5. Next Steps

Style guide footer: “Note completed immediately after session.”

7. Style Guide for Incident Reports

- Document only observable actions.
- Avoid hypothetical motives or predictions.
- Specify notifications made, times, and persons contacted.

8. Style Guide for Multidisciplinary Summaries

- Separate lanes for medical facts, behavioral observations, family/legal context, and provider recommendations.
- Highlight misalignment neutrally: “Recommended by X on date; not approved by Y as of date.”

9. Formatting Standards

- 12–14 pt sans-serif
- Clear spacing and visual blocks
- No use of red as the sole emphasis color
- Step indicators for multi-section forms

10. Accountability Features

- Date and time-stamp every entry
- Attribute decisions (full name and title)
- Distinguish fact vs inference
- Track missing or denied information

- Optional high-risk add-ons: care-denial tracking, caregiver visibility notes, and Safety Narrative Anchor updated for each event

---

Style Guide Worked Example

The style guide elements are marked in **bold**.

Case Note: Annual Medical Exam

Date/Time: 01/14/2026, 10:42 AM
Practitioner: Jamie Ortiz, FNP
Client: C.F., age 6

Context

The child attended her scheduled annual exam with her foster caregiver present. The visit included a height/weight check, hearing/vision screening, and a routine immunization review. **Client Goals:** maintain good health, address sleep concerns, support kindergarten readiness. **Micro-consent:** Child nodded agreement before each exam step. **Why we ask:** To help track changes over time and reduce repeated questioning. **Retelling-protection:** Sleep concerns previously documented in note dated 11/04/2025; referenced here without repeating details.

Client Voice

Child **stated** she "likes school" and **noted** she "gets tired at night" but "doesn't like loud machines" when the discussion of a possible sleep study arose. She **identified** her goal as "feeling less scared at bedtime."

Practitioner Observation

The practitioner **observed** the child to be calm, cooperative, and responsive to simple questions. No acute distress noted. Growth measurements fall within expected parameters. The practitioner **noted** mild dark circles under the eyes and **observed** increased blinking during the vision screen, recommending follow-up. Neutral, non-pathologizing language is maintained in accordance with **Safety and predictability**, **Neutral, observable language**, and **Ensure specificity, clarity, and traceability**.

Actions + Choices Offered

Practitioner **offered** options for managing sleep concerns (routine adjustments, environmental supports). The caregiver selected a trial of the behavioral sleep chart before referral to a specialist. Practitioner **provided** immunization review; no vaccines due today. The caregiver **chose** to schedule a vision follow-up. All actions aligned with **Maintain client agency, choice, and consent**.

Next Steps

1. Caregiver to begin sleep-routine chart (1/15/2026).
2. Vision referral submitted today.
3. Follow-up primary care appointment in 6 months.
4. Any new symptoms to be documented in the next **Multidisciplinary Summary**.

Note completed immediately after the session.