FINAL EXAMINATION REVIEW · DAY 2, AFTER LECTURES 3 AND 4

RU RMT 12 — Health & Safety

Final Examination Review — All Four Lectures

A worked review session covering Lecture 1 (Modules 1–6), Lecture 2 (Modules 7–12), Lecture 3 (Modules 13–18) and Lecture 4 (Modules 19–24), delivered on Day 2 once all four lectures have been taught.

Field	Detail	Field	Detail
Review session	Day 2, after Lectures 3 and 4	Session length	Approximately 90 minutes
Reviews for	The final examination, written Day 3	Covers	All four lectures, Modules 1–24
Exam format	50 multiple-choice questions, 90 minutes	Exam weight	30% of the final grade
Exam conditions	Closed book — no aids	Passing standard	70% (course-level)
This document	Open — bring it to the session	At the exam	Not permitted at your desk

1. How to use this review

This is not a summary to read. It is a session to work. Everything in it is retrieval practice — you cover the answer, attempt it aloud or on paper, and only then check. Reading a review and recognizing the content produces a comfortable feeling and almost no learning; attempting to recall it, failing, and then correcting is what moves it into the exam.

- Section 3 is a rapid-recall drill of about 95 prompts across the four lectures. Cover the right-hand column. Work in pairs if you can — one asks, one answers, then swap.
- Section 4 is the six through-lines. If you know these, most scenario questions answer themselves, because most of them are testing one of the six.
- Section 5 is the distinctions that decide answers. Almost every wrong answer in this course is one of these pairs collapsed into the other.
- Section 6 is eight scenario drills with worked reasoning — these are closest to how the examination actually asks.
- Section 7 is the traps. Read this the night before the exam if you read nothing else.
- Mark anything you could not recall and go back to that module tonight. An honest gap found today is worth more than a comfortable read-through.
- None of the questions in this review appear on the examination. They rehearse the same competencies through different situations, which is the point — the exam will not ask you what you memorized, it will ask you what you can apply.

2. What the examination covers

The examination is cumulative across all four lectures. It is organized into four sections, one per lecture. Roughly three questions in five ask you to apply a standard to a clinic situation rather than to recall a list — so revise by reasoning, not by memorizing.

Section	What it assesses	Items	Share
A · Lecture 1	Regulation, OHS law, the IRS, worker rights, WHMIS, the practice setting, hazard and risk, the hierarchy of controls, microbiology	13	26%
B · Lecture 2	Routine practices, PCRA, hand hygiene and PPE, Spaulding, contact time, linens, communicable disease and exposure, consent, draping, screening, public health	14	28%
C · Lecture 3	Occupational health and body mechanics, psychosocial safety and harassment, emergencies, incident management and investigation, safety culture, WHMIS in practice	13	26%
D · Lecture 4	Community support, the circle of care and consent to disclose, referral, advocacy and misinformation, cultural safety, trauma-informed care, accessibility, ethics and mandatory reporting	10	20%
TOTAL	Modules 1–24	50	100%

MARKS AND TIMING

- 50 questions, 1 mark each, 90 minutes — about 1 minute 45 seconds per item. If you are past question 25 at the 45-minute mark you are on pace.
- One best answer per question. All-or-nothing marking: no part marks, and 0 for a blank, two letters, or an illegible letter.
- No penalty for a wrong answer. Never leave a blank — eliminate what you can and choose.
- 35 / 50 is 70%. This examination carries 30% of the course, so a weak score here is recoverable — but the Final Oral Practical is a must-pass component and cannot be compensated for.
- Mark hard items and move on. Do not spend five minutes on one mark.
- Sections A and B together are 27 of the 50 marks. Do not over-revise Lectures 3 and 4 simply because they are freshest in your mind.

3. Rapid-recall drill — cover the answers

Work down each list. Say the answer before you look. Anything you miss goes on tonight's list.

LECTURE 1 · FOUNDATIONS, LEGISLATION, WHMIS, THE SETTING, RISK, MICROBIOLOGY

Prompt	Answer
What is the regulatory promise that every standard descends from?	Care must be safe, effective and ethical. Public protection is the reason the profession is regulated at all.
CMTCA accredits what? The College regulates what?	CMTCA accredits the education program. The College registers and disciplines the individual, and governs how you practise.
Does OHS law apply to a self-employed RMT working alone?	Yes — every workplace, including home-based practice and self-employment. You hold employer, supervisor and worker duties at once.
What are you, in law, on clinical placement?	A worker. The duties and the rights both attach from day one.
Name the three worker rights.	To KNOW, to PARTICIPATE, to REFUSE. Legislated — they cannot be signed away in a contract.
First action in a work refusal?	Stop the work and stay at the workplace in a safe place; then promptly report the refusal and the reason to your supervisor.
Who ends a refusal that cannot be resolved?	A government inspector, by written decision, which binds the parties.
The three pillars of WHMIS?	Labels + Safety Data Sheets + Education and training.
Three elements of a workplace label?	Product identifier · safe-handling precautions · reference to the SDS.
When is a workplace label required?	Whenever a product is decanted, and where the supplier label is lost or illegible.
A supplier label wiped illegible by alcohol — what now?	It is legally no label at all. Relabel before use.
SDS: eye splash? Storage? Gloves? Mixing? Currency?	4 · 7 · 8 · 10 · 16.
Bleach + ammonia = ?	Chloramine gas — toxic at low concentration in an enclosed treatment room. Never mix; never top up a bottle with a different product.
Hazard vs risk?	Hazard = potential to cause harm; a fact. Risk = likelihood × severity; a judgment.
Hierarchy of controls, most to least effective?	Elimination · substitution · engineering · administrative · PPE.
Which risk-assessment step is most often skipped?	Step 4 — record the findings: hazard, control, person responsible, date.
Which service-log entry is the classic failure?	The date the item was returned to service, and by whom.
Name the six links of the chain of infection.	Infectious agent · reservoir · portal of exit · mode of transmission · portal of entry · susceptible host.
Which flora cause most cross-contamination, and why does that matter?	Transient — they sit loosely on the surface and are easily removed. That removability is the whole basis of hand hygiene.
Why must cleaning precede disinfection?	Organic matter — oil, lotion, skin cells — physically shields microbes. You cannot disinfect through a film of massage oil.
What is a biofilm, and how do you deal with one?	Organisms under a protective matrix — in an oil bottle, lotion pump or footbath. Dramatically disinfectant-resistant; must be physically removed. Spraying does not work.
What does a DIN confirm?	That the disinfectant is authorized in Canada and kills the microbes claimed on its label.

LECTURE 2 · IPAC, HAND HYGIENE & PPE, CLEANING, LINENS, CLIENT SAFETY, PUBLIC HEALTH

Prompt	Answer
State routine practices in one sentence.	Treat all blood, body fluids, secretions, excretions and non-intact skin as infectious — every client, every time, regardless of what you know or assume.
Why 'every client, every time'?	Infectivity often precedes symptoms, and the alternative is guessing about people. Selective application is unsafe and discriminatory.
The three PCRA questions?	What is the task? What is my risk of exposure? What controls does that require?
The four moments for hand hygiene?	1 before client contact · 2 before a clean/aseptic task · 3 after body-fluid exposure risk · 4 after the client and their surroundings.
You adjust a bolster then touch the face cradle. Which moment?	Moment 4 — the client's surroundings. Re-perform hand hygiene before returning to skin.
Soap and water, or rub — hands coated in oil?	Soap and water. Oil and lotion count as visible soil.
Durations?	Lather 15–20 seconds; rub until completely dry, roughly 20–30 seconds.
'Bare below the elbows' means?	Short sleeves, no rings, no watch or bracelets, short natural nails — no gel, no extensions, no chipped polish.
Do gloves replace hand hygiene?	Never. Hands contaminate during removal, and gloves can have unseen defects.
Doffing order, and the principle?	Gloves → hand hygiene → gown → eye protection → mask → hand hygiene. The outside front of every item is contaminated: remove the dirtiest first, touch only what stayed clean.
Spaulding: massage table?	Non-critical — clean, then low-level disinfect, between every client.
Define contact time.	The period the surface must stay visibly wet for the label's kill claim to be achieved. Not a suggestion — it is the condition the product was licensed under.
Surface dries before the time elapses?	The claim is void. Re-apply — do not wipe harder.
Ninety-second turnover, five-minute contact time. Whose failure?	The schedule's. That is an administrative control failure, not a therapist failure. If the schedule doesn't allow it, the schedule is the hazard.
Why never shake soiled linen?	It aerosolizes skin cells and organisms into the room you have just disinfected. Roll it inward, straight into a covered hamper.
Clean stack carried with a soiled bundle?	The clean stack is now a soiled stack.
Face-cradle cover that looks clean?	Soiled. Single-client use is the standard; 'it looks clean' is not.
Therapist with fever and vomiting, six clients booked?	Stay home, do not attend, notify the clinic promptly so appointments are rescheduled. Deferring is a professional duty, never grounds for reprisal.
Exposure response, five steps?	Stop and cover · wash with soap and water · clean and disinfect · report and seek medical assessment promptly · document.
Which blood-borne pathogen has a vaccine?	Hepatitis B — strongly recommended for health-care providers including massage therapists.
A client's insulin needle on the floor?	Directly into a puncture-proof sharps container. Never recap by hand, never the linen hamper, never general waste.

Prompt	Answer
Client booked 'full body' — consent for gluteal work?	No. Specific consent for that area, at that visit, documented. There is no implied consent.
Client goes silent and tenses mid-treatment?	Silence is not consent. Check in actively about pressure, comfort and warmth.
Who controls the drape through a turn?	You do — held and controlled through the turn, never left to the client. Re-drape before continuing.
Three categories of contraindication?	Absolute (do not treat, refer) · local (avoid the area, treat elsewhere) · relative/conditional (modify, clearance where needed).
Established client of three years — screening?	Re-screen at every visit. The intake form is a snapshot; the re-screen is the practice.
A directive is issued by the Chief Medical Officer of Health?	Follow the version in force today, promptly. Not the version you were taught, and not subject to client consent.

LECTURE 3 · OCCUPATIONAL HEALTH, PSYCHOSOCIAL SAFETY, EMERGENCIES, INCIDENTS, SAFETY CULTURE

Prompt	Answer
Four occupational hazard categories for an RMT?	Musculoskeletal · physical fatigue · psychosocial · exposure.
Characterize therapist injury in one sentence.	Most are cumulative and preventable — they develop slowly and respond well to good habits early.
Three early warning signs of RSI?	Aching, tingling, weakness or numbness lingering after work. Persisting overnight, or starting earlier each week, is the signal.
Classmate hiding thumb pain to protect their placement?	Report, modify, seek care early. Reporting is an IRS duty, not weakness — and no worker may be penalized for it. Never push through pain.
Where does pressure come from?	The floor, through the legs, by shifting bodyweight through a lunge — not from pushing with the arms.
The master variable in table set-up?	Table height. Too low is the most common cause of back strain in new therapists — and it takes six seconds to adjust.
The thumb is what kind of tool?	A precision tool, not a pressure tool. Use forearms, elbows, fists, supported hands.
Varying your tools across the day is which kind of control?	An engineering control — on your own body.
Client makes a sexualized request mid-treatment?	End the treatment, remove yourself, leave. You owe no explanation, no remainder of the hour, no refund negotiation in that moment.
When do you write the harassment record?	The same day. Date and time, their words as closely as recalled, what you said and did, who else was present or informed, what happened next. No editorializing, no minimizing.
Four warning signs of burnout?	Exhaustion · cynicism · dread before work · a reduced sense of accomplishment.
The first-aid sequence?	Check → Call → Care → Hand over.
What is wrong with 'someone call 911'?	It means nobody calls. Point at a specific person and give them the task.
Client faints after standing up?	Lie them down, elevate the legs, loosen tight clothing, let them recover slowly. Never leave them alone.
Why is post-treatment fainting predictable?	Warm, relaxed, barefoot, possibly hypotensive after an hour prone. The last two minutes are the highest-risk two minutes.

Prompt	Answer
Fire alarm, client prone and draped?	A drape or robe is enough. Nearest safe exit, no belongings, no elevators, assembly point, account for everyone, do not re-enter. Life over property — and over dignity if it comes to it.
Incident response, five steps?	Make safe · get help · record · report · review. The hazard first, then the paperwork.
Bolster slips, client startled but unhurt?	A near-miss — recorded, reported, reviewed. It is the free lesson.
'The therapist slipped' — is that a cause?	No. It is where the investigation starts. Ask why until you reach the system: no restock routine, no cloth in the room.
Why is retraining a weak corrective action?	It is an administrative control — one of the weakest — and it does not change the system that produced the incident.
Four reporting destinations?	Supervisor/clinic (every incident and near-miss) · health and safety authority (serious/critical injury) · your College (mandatory reports) · public health (reportable conditions).
Unsure whether something is reportable?	Ask your regulator. Under-reporting carries real professional risk, and 'I didn't know' is not a defence.
What kills a safety culture?	Blame — it produces silence, and silence produces repetition. A report that produces nothing teaches everyone not to report.

LECTURE 4 · COMMUNITY SUPPORT, COLLABORATION & REFERRAL, ADVOCACY, VULNERABLE POPULATIONS, ETHICS

Prompt	Answer
Is community support charity?	No — a professional obligation. Regulation is granted in exchange for public protection, and that does not stop at the treatment-room door.
Why is it in a health and safety course?	Because community harm is still harm: a missed referral, unchallenged misinformation, an inaccessible clinic, an unreported suspicion.
Three words that define the goal?	Safe · integrated · accessible. A profession can be perfectly safe and still fail the community by being unreachable or unaffordable.
What is the circle of care — and its limit?	Providers involved in that client's care, sharing relevant information for that purpose, with the client's knowledge and consent. Not free discussion with anyone in health care.
Consent to treat = consent to disclose?	No. Separate decisions; the client makes both. Ask specifically: who, what, why.
An undocumented disclosure is…?	Indistinguishable from an unauthorized one.
'You should see someone about that' is?	Not a referral — it is the end of your involvement dressed up as care.
Client discloses suicidal ideation?	Match urgency to the pathway. A crisis is not a business card: crisis line or emergency services now, in the room. Listen, don't probe, refer, document.
What makes a referral warm?	A name, a number, the first step; offering to make the call; asking if they want you to stay; following up next visit.
Scope vs competence?	Different limits, and both bind. Outside massage therapy entirely, or within it but beyond your current training.
Client stopping a medication because of something they read?	Lead with the accurate information, don't repeat the false claim, explain briefly, don't shame, refer to the prescriber.

Prompt	Answer
Why not shame them?	Trust is the mechanism. A client who feels judged stops telling you what they are doing — and a client who conceals cannot be screened.
The hardest misinformation to correct?	The flattering kind, told about your own profession.
Who decides whether an encounter was culturally safe?	The client. 'I didn't mean anything by it' is not a defence and is not relevant to whether harm occurred.
Is cultural safety a checklist of cultures?	No — that produces stereotyping. It is a stance: self-reflection, recognising your authority in the room, asking rather than assuming.
Trauma-informed care asks which question?	Not 'what is wrong with this person' but 'what has happened to this person'.
Client goes still and agrees to everything?	Compliance is not consent; stillness is not comfort. Stop and check rather than working through it.
Is trauma-informed the same as trauma-treating?	No. Make the encounter safe and refer. Applied universally, like routine practices — you cannot tell by looking.
Accessibility — what does legislation give you?	A floor. The obligation is to ask honestly who your clinic currently excludes.
Free massage in a marquee, no sink, no charts?	Consent, draping, screening, hand hygiene, records and scope apply identically. If you cannot deliver them, change the set-up or decline.
Does a free treatment carry a lower standard?	No. Free is a fee decision, not a professional one. The standard travels with the registration, not the building.
Mandatory reporting — what is the threshold?	Reasonable grounds to suspect. Not proof, not certainty. You are not the investigator; you are the reporter.
Does confidentiality override a reporting duty?	No — a mandatory report is an authorized disclosure.
Does telling the clinic owner discharge it?	Generally no. The duty rests personally on whoever formed the suspicion.

4. The six through-lines — the spine of the whole course

Each of these appears in every lecture. Most scenario questions on the examination are testing one of the six. If you can name them and say where each appears, you can reason your way through items you have never seen.

Through-line	What it means · where it appears
Public protection is the purpose	Every standard, by-law and protocol descends from one promise: care must be safe, effective and ethical. It is why the profession is regulated, why the program is accredited, and why community harm counts as harm. (L1 M1 · L2 M12 · L4 M19)
Assume, don't guess	Routine practices, the PCRA, treating every client and every fluid as potentially infectious — you cannot tell by looking. The same logic drives trauma-informed care: applied to everyone, because you cannot identify who needs it. (L1 M6 · L2 M7 · L4 M22)
Reach up the hierarchy of controls	Elimination beats substitution beats engineering beats administration beats PPE. It explains why a schedule with no turnover time is the hazard, and why retraining one person is a weak fix for a system failure. (L1 M5 · L2 M9 · L3 M16, M18)
If it isn't written, it didn't happen	Risk assessments, cleaning and maintenance logs, incident and near-miss reports, consent, disclosures, training records. Documentation protects the client, supports improvement, and protects you. Its corollary: what is written must be true. (L1 M5 · L2 M11 · L3 M16 · L4 M20)
Safety is shared	The Internal Responsibility System: employer, supervisor, worker, student and client each hold a part. Accountability rises with authority, but the duty to notice and report attaches to everyone — including you, from your first placement day. (L1 M2 · L3 M17)
Competence expires; the duty does not	Certifications lapse, directives change, evidence moves. You practise under the version in force today, not the version you were taught. (L1 M1 · L2 M12 · L3 M17 · L4 M21)

5. The distinctions that decide answers

Almost every wrong answer in this course is one of these pairs collapsed into the other. Be able to state both sides of each.

Distinction	One side	The other side
CMTCA vs the College	Accredits the program that educates you	Registers and disciplines you; sets Standards of Practice; mandate is public protection
Hazard vs risk	Potential to cause harm — a fact	Likelihood × severity — a judgment about exposure and consequence
Clean vs disinfect vs sterilize	Remove soil and the organic shield; kills nothing	Disinfect: kill most pathogens on objects. Sterilize: kill all life including spores — rarely needed in massage
Resident vs transient flora	Deep skin layers; hard to remove; rarely cause infection	Surface; acquired all day; cause most cross-contamination; easily removed — the basis of hand hygiene
Supplier vs workplace label	Six elements, manufacturer's, on the original container	Three elements — identifier, handling precautions, SDS reference — on anything decanted
Absolute vs local vs relative	Do not treat; refer. The answer is no, not 'gently'	Local: avoid the area, treat elsewhere. Relative: modify, clearance where needed
Soap vs alcohol-based rub	Visibly soiled, after the washroom, before eating, spores	Everything else — faster and gentler. Oil counts as visible soil

Distinction	One side	The other side
Scope vs competence	Outside massage therapy altogether	Within it, but beyond your current training. Different limits; both bind
Education vs treatment	A workshop is education — no assessing, diagnosing or treating individuals	Hands on a person as an RMT is treatment, and every standard applies in full
Cultural awareness vs safety	What you know about a group	How the client experienced the encounter — and only they can judge it

6. Scenario drills — how the examination actually asks

Work each one before reading the response. Say what the standard requires, what you would do, and what you would document. These are new situations — none of them is an examination question — but the reasoning is exactly what Day 3 assesses.

Scenario 1 · *L1 M5 · L2 M9*

You are running 20 minutes late. The next client is waiting. The table was wiped 40 seconds ago with a product whose label states a three-minute contact time, and the face-cradle cover from the last client still looks perfectly clean.

What has gone wrong, whose failure is it, and what do you do?

WORKED RESPONSE

Two breaches. The table is not disinfected — the claim is void unless the surface stays visibly wet for the full three minutes; re-apply and let it dwell. The cover is soiled regardless of appearance: single-client use is the standard, so replace it. The failure is not primarily yours: a booking schedule that leaves no turnover time is an administrative control failure, and the schedule is the hazard. Raise it — under the IRS, the person closest to the work is obliged to report rather than absorb it.

Scenario 2 · *L2 M11 · L4 M20*

A client you have treated monthly for two years arrives for a routine appointment. Nothing on their file has changed. They mention in passing that they 'had a bit of a health scare last month' but do not elaborate.

What does the standard require?

WORKED RESPONSE

Re-screen — at this visit, before treatment. Health status changes between appointments, and the intake form is a snapshot while the re-screen is the practice. Familiarity does not reduce the obligation; a long-standing client is not a lesser screening duty. Depending on what the re-screen finds, the presentation may be a relative/conditional contraindication requiring modification or physician clearance — and collaboration within the circle of care, with specific consent, is how you confirm what is safe. Document what you asked and what they said.

Scenario 3 · *L1 M1 · L1 M3 · L3 M18*

You find a spray bottle of clear liquid on the shelf in treatment room 2. It is unlabelled. A colleague says 'that's just the disinfectant, it's fine.'

What is your response, and what standards are engaged?

WORKED RESPONSE

Do not use it. If a container is not clearly labelled, confirm the contents and label it first — a workplace label needs the product identifier, safe-handling precautions and a reference to the SDS. An unlabelled container denies every other worker their statutory right to know: nobody can know the dilution, the contact time, or what to do if it reaches an eye. This single act engages OHS law, the College's safe-and-sanitary-setting standard, and the expectations of an accredited program — all three at once. It is a citable violation, and it is ten seconds and a marker to fix.

Scenario 4 · *L2 M10*

Mid-treatment your ungloved finger contacts blood from a lesion that has opened. You are 15 minutes from the end of the appointment.

What is the sequence?

WORKED RESPONSE

Stop and cover — immediately, not at the end. Cover any wound on you and on the client. Wash the exposed site with soap and water; do not scrub, squeeze or apply bleach. Clean and disinfect the surfaces involved and dispose of contaminated items as regulated waste. Report to your supervisor and seek medical assessment promptly — timing matters for post-exposure follow-up, so this does not wait until the end of the day. Then document the facts and the actions in an incident report.

Routine practices, not a health-history question, are what protect you: you will not know the client's status and neither may they.

Scenario 5 · *L2 M11 · L4 M20 · L4 M21*

A client on the table asks whether they should stop taking the blood thinner their doctor prescribed, because they read online that it is dangerous. They also mention it is not on their file.

How do you respond, and what else does this trigger?

WORKED RESPONSE

Two things at once. On the misinformation: lead with the accurate information, do not repeat the false claim, explain briefly, do not shame them — and because this concerns a medication, the correction is a referral to the prescriber. Contradicting prescribed treatment from the table is outside your scope; directing them to their prescriber is within it. On the disclosure: this is a relative/conditional contraindication caught by re-screening. Blood thinners change what pressure means. Modify, seek clearance where indicated, and document. Note why the shaming point is a safety point: a client who feels judged stops telling you what they are doing, and a client who conceals cannot be screened.

Scenario 6 · *L4 M23*

You are asked to work at a charity fundraiser: massage chairs in a hotel lobby, a queue of thirty people, no sink, no intake forms, no fee charged.

Can you treat? What must be true first?

WORKED RESPONSE

Only if consent, draping, screening, hand hygiene, records and scope can all be delivered — because the setting changes and the relationship does not. That lobby is a treatment room the moment you put hands on someone as an RMT. If you cannot screen a queue of thirty, cannot perform hand hygiene without a sink, and cannot make a record, then you change the set-up — alcohol-based rub at the point of care, a short screening tool, a simple record — or you decline. Nobody consents to a reduced standard because they were not charged: free is a fee decision, not a professional one. The standard travels with the registration, not the building.

Scenario 7 · *L1 M2 · L1 M4 · L3 M17*

A student on placement notices the hydraulic table in room 1 drifts down under load. They mention it to the receptionist, who says the owner already knows. The student uses it anyway because their client is waiting.

Identify every failure here.

WORKED RESPONSE

The equipment: a table that faults, drifts or makes a new noise is stopped immediately, tagged out so it cannot be used, and the fault and the removal from service recorded in the equipment log — with the return-to-service entry when it comes back. 'Be careful with it' is not a control. The student: as a worker in law from day one, they hold the duty to report defects and the right to refuse work they reasonably believe is dangerous — and clinic policy cannot override a statutory right. Mentioning it to reception is not reporting it to a supervisor. The system: 'the owner already knows' with the table still in service means the report produced nothing, which teaches everyone not to report — the failure mode of the IRS. And the client is the one who climbs onto it.

Scenario 8 · *L4 M20 · L4 M22 · L4 M23*

During a treatment a client discloses that they are frightened of their partner and asks you not to tell anyone. They have a child at home.

What are your obligations, and what are the limits of your role?

WORKED RESPONSE

Stay inside your scope: listen, do not probe, thank them, ask what they need now, and refer warmly — a name, a number, the first step, and an offer to make the call. You are not a counsellor, and trauma-informed does not mean trauma-treating. On the child: if what you have heard gives you reasonable grounds to suspect a child is being abused, the duty is triggered by

suspicion, not proof; it typically rests personally on you and is not discharged by telling the clinic owner; and confidentiality does not override it, because a mandatory report is an authorized disclosure. You are the reporter, not the investigator. Know your jurisdiction's threshold, recipient and timeline before you are standing in front of this — ask your instructor for the contact points today, not on the day.

7. Traps — the wrong answers this course is built to catch

Distractors on the examination are built from real clinical errors, not from nonsense. These ten patterns account for most of them.

Trap	How to spot it
The convenience exception	Any option excusing a step because you are busy, running late, or the client is waiting. Safety obligations have no convenience exceptions. If the schedule makes compliance impossible, the schedule is the hazard.
'It looks clean'	Appearance is never a standard. A cover that touched a client is soiled; a table with an invisible oil film cannot be disinfected; a surface that dried early was not disinfected.
Gloves as a substitute	Gloves supplement hand hygiene, never replace it — hands contaminate during removal. And gloves are chosen from the PCRA, not from habit or fear.
PPE as the first answer	PPE is the last line of the hierarchy. If an option offers elimination, substitution or an engineering control for the same hazard, PPE is not the best answer.
Blaming the person	'Retrain the therapist', 'be more careful', 'remind staff' are administrative controls — among the weakest. Look for the system: the missing restock routine, the schedule with no margin.
Consent as a signature	Consent is a continuous conversation. An intake form is not standing consent, a booking description is not consent to a sensitive area, and silence is not consent.
Familiarity discounts	A long-standing client is not a lesser screening, consent or draping obligation. Vulnerability does not diminish with familiarity.
Asking instead of assuming	Routine practices exist because you cannot tell by looking and the client may not know. A health-history question about infection status does not protect you; universal precautions do.
The accreditor/regulator swap	CMTCA accredits the program. The College regulates you. Neither promotes the profession's interests.
Waiting for permission	Directives in force bind you today. Statutory rights cannot be waived by contract. A mandatory report is not discharged by telling your employer.

8. Tonight and tomorrow

TONIGHT

- Go back only to what you could not recall in section 3. Do not re-read what you already knew — it feels productive and teaches nothing.
- Re-run the six through-lines from memory. Name two modules for each.
- Say both sides of every distinction in section 5 out loud.
- Re-read section 7 last thing. It is the highest-yield page in this document.
- Sleep. Recall degrades with fatigue, and the examination is written tomorrow.

TOMORROW — EXAMINATION DAY

- Bring photo identification. Arrive early.
- Bags, coats and all electronic devices go to the front of the room — powered off, not silenced. Phones, smart watches, earbuds and fitness trackers are all devices.
- Closed book: no notes, no slides, no handouts. This review document may not be at your desk.
- Print your name and student number before you begin. An unnamed paper cannot be marked.
- Read each stem twice. Note the qualifiers — FIRST, MOST effective, BEST describes, NOT — because they decide the answer.
- Predict the answer before you read the options, then find the option closest to your prediction.
- Answer from the standard as taught, not from what you have seen done on placement. A common clinic practice can still be the wrong answer.
- Attempt every question. Mark the hard ones, move on, come back.
- Change an answer only if you have a reason. A vague second-guess is usually worse than your first reading.
- Raise your hand for a suspected typographical error. Invigilators cannot interpret questions or confirm answers.

ACADEMIC INTEGRITY

The examination is governed by the Ruhani College Academic Integrity Policy in your student manual. By submitting your paper you declare the work is your own and that you neither gave nor received unauthorized assistance. Unauthorized material or a device at your desk, communication with another student, or removing, photographing or transcribing examination content are violations — and because this is a cumulative final whose items are reused across deliveries, passing content to another cohort devalues the credential you are working for. A substantiated breach on an assessment carrying 30% caps your aggregate at 70% and in practice makes the course unrecoverable. If a violation is suspected you will be told the allegation and given a genuine opportunity to respond before any finding is made, with a right of appeal.

Note: this review is prepared from the RU RMT 12 lecture materials. Where it differs from the approved course syllabus or the Ruhani College Student Manual, those documents govern. Competency and standard numbering, regulatory citations and provincial procedures should be confirmed against the current College Standards of Practice and the inter-jurisdictional competency document. If you spot a discrepancy, raise it — noticing it is itself a professional skill.

You are entering a regulated health profession. The client on your table cannot see your hand hygiene, cannot assess your table's condition, and cannot know whether you respected the contact time. They rely entirely on what you do when nobody is watching. That is what a competency means — and it is why safety is a competency, not a checklist.

Good luck tomorrow.