STUDENT HANDOUT · STUDY GUIDE

RU RMT 12 — Health & Safety

Final Examination — Study Guide & Preparation Handout

Everything you need to know about the final examination: what it covers across all four lectures, how it is marked, what to study, and how to prepare.

1. The final examination at a glance

Field	Detail	Field	Detail
When	Day 3 of 3	Format	50 multiple-choice questions
Covers	All four lectures — cumulative	Marks	50 (1 mark per question)
Weight	30% of your final grade	Duration	90 minutes
Passing standard	70% (course-level)	Aids permitted	None — closed book
Answer format	One letter: A, B, C or D	Wrong answers	No penalty — never leave a blank

2. What the final examination assesses

The examination is cumulative. It assesses the whole course — including the Lecture 1 and Lecture 2 material you were already assessed on in Quiz 1. That material is not repeated as the same questions: it returns as new scenarios and new applications, so revising Quiz 1 answers is not a substitute for understanding the content.

The paper is organized into four sections, one per lecture. The blueprint below shows how the 50 questions are distributed.

Section / module block	What you are expected to be able to do	Items	Share
A · L1 — Foundations, legislation, WHMIS, setting, risk, microbiology	Apply OHS law and the IRS; exercise worker rights; read labels and SDSs; distinguish hazard from risk; apply the hierarchy; explain the chain of infection	13	26%
B · L2 — IPAC, hand hygiene & PPE, cleaning, linens, client safety, public health	Apply routine practices and the PCRA; hand hygiene and PPE; Spaulding and contact time; consent, draping, screening; outbreak directives	14	28%
C · L3 — Occupational health, psychosocial safety, emergencies, incidents, safety culture	Prevent your own injury; respond to violence and harassment; recognize burnout; respond to emergencies; manage and investigate incidents; report correctly	13	26%
D · L4 — Community support, collaboration, advocacy, vulnerable populations, ethics	Collaborate within the circle of care with consent; refer safely; correct misinformation; apply cultural safety, trauma-informed care and accessibility; meet reporting duties	10	20%
TOTAL	The full course, Modules 1–24	50	100%

Most questions are scenario-based: you are given a clinic situation and asked what the standard requires. Roughly three in five items ask you to apply a rule to a case rather than recall a list. Your instructor will confirm before the examination whether Lecture 4 has been delivered to your cohort and is within scope — if it is not, Section D is removed and the paper is marked out of 40. Ask if you are unsure; you are entitled to know exactly what you are assessed on.

3. How the final examination is marked

- Each question is worth 1 mark, with exactly one best answer.
- Marking is all-or-nothing per question: 1 mark for the correct letter, 0 for anything else. No part marks.
- You score 0 for a blank, for two or more letters recorded, and for a letter that cannot be read.
- There is no penalty for a wrong answer. Attempt every question — a guess is worth more than a blank.
- Your raw score out of 50 converts to a percentage, contributing 30 points to your final grade. 40/50 = 80% = 24.0 of the available 30 points.
- The passing standard for RU RMT 12 is 70%, applied to your final aggregate grade. On this paper, 70% is 35 out of 50.
- This examination carries 30% of the course. A weak score here is recoverable — but only if your practical, quiz and assignment marks are strong, and the Final Oral Practical is a must-pass component you cannot compensate for. If you score 70% on everything else you need 70% here; at 80% elsewhere you need about 47% here.
- Percentages are rounded once, at reporting, to the nearest whole number.
- Passing this examination does not by itself complete the course. Completion requires demonstrated competence: the written assessments, demonstrated hand hygiene and PPE competency, safe body mechanics at the table, the incident-reporting exercise, and current first-aid and CPR certification at the level your program and College require.
- Results, paper inspection, remediation and appeals follow the processes in your student manual.

WHERE THE FINAL EXAMINATION SITS IN YOUR GRADE

Assessment	When	Weight	Status
Assignment	Released Day 1, due Day 3	10%	Due on the same day as this examination
Quiz 1	Day 2	20%	Lectures 1–2; re-assessed here cumulatively
Final examination	Day 3	30%	This assessment — all four lectures
Final Oral Practical	Day 3	30%	IPAC practical station — must-pass at 28/40
Professionalism	Throughout	10%	Includes your conduct during this examination
Worksheet	Throughout	—	Practice and consolidation; not separately weighted
TOTAL		100%	

4. Content review — Lecture 1

Sections 4 to 7 summarize the whole course, module by module. This is a revision aid, not a replacement for the slides and your own notes. Anything here you cannot explain in your own words is a gap to close.

LECTURE 1 · DAY 1 — THE SYSTEM AND THE SETTING

Module 1 · Why health & safety is central to massage therapy

Massage therapy is a regulated health profession in five Canadian provinces. The regulatory promise is that care must be safe, effective and ethical — every standard, by-law and protocol in this course descends from that one promise, and public protection is the reason the profession is regulated at all.

Six features make this work distinctive: close sustained physical contact; client vulnerability (draped, often asleep, unable to see you); shared surfaces and equipment; force and repetition on your own body; chemicals and biological material; and simultaneous legal accountability to OHS law, the College, the client, the employer and the insurer.

Three duties sit on every RMT at once — protecting the public, protecting yourself, and meeting your legal duty. They rarely conflict: a practice that protects the client almost always protects the therapist and satisfies the law.

REMEMBER

- *The client cannot assess your hand hygiene, your table's condition or your disinfectant's contact time. They rely entirely on your discipline when nobody is watching.*
- *Ignorance of a standard is not a defence at a discipline hearing.*

Module 1 · The regulatory & legal landscape — four layers

CMTCA (Canadian Massage Therapy Council for Accreditation) accredits education programs against national standards. It does not regulate you as an individual — it regulates the program that educates you.

Regulatory Colleges (for example the CMTO in Ontario) set Standards of Practice, a Code of Ethics, entry-to-practice requirements and by-laws, and hold discipline authority. Their statutory mandate is public protection — not promotion of the profession's interests.

Entry-to-practice competencies (the inter-jurisdictional practice competencies) define the minimum safe, effective and ethical performance expected of a new RMT on day one. Safety & Risk Management is one of the competency domains and is examinable on the certification examination.

Occupational Health & Safety law applies to every workplace — clinics, spas, franchises, multidisciplinary offices, home-based practice and self-employment. It is enforced by government inspectors and carries fines and prosecution, entirely separately from College discipline.

REMEMBER

- *Accreditation shapes your education · the College governs your practice · OHS law governs your workplace. A single act — using an unlabelled disinfectant — can breach all three at once.*
- *Do not confuse the accreditor with the regulator. Neither is a professional association or advocacy body.*

Module 1 · The Safety & Risk Management standard

The practice setting must be clean and sanitary (cleaned and disinfected regularly, including equipment, linens and high-touch surfaces, using products used according to their directions); safe and private (lit and arranged to give each client

sufficient physical privacy and safety); and documented (maintenance recorded in a service log, hazards managed proactively).

Three ongoing duties: follow health and safety directives currently in force; handle hazardous materials safely per WHMIS and dispose of contaminated material as regulated waste; and maintain competence through training and certification, with records that demonstrate it.

REMEMBER

- *Directives change — the obligation is to practise under the version in force today, not the version you were taught.*
- *Competence is not a one-time achievement. Certification lapses; the duty does not.*

Module 2 · The Internal Responsibility System (IRS) and the four roles

The IRS is the foundation of Canadian OHS law: everyone in the workplace has a role in keeping it safe, according to their authority and their ability. The people closest to the work are best placed to see the hazard, and are obliged to act rather than wait for an inspector.

Employer / clinic — provide a safe environment, safe equipment, training, written policies and competent supervision; take every reasonable precaution for the protection of the worker. Ultimate accountability rests here.

Supervisor — ensure workers follow procedures, use the protective measures provided, and are informed of every hazard they may encounter. A supervisor must not knowingly permit unsafe work to continue.

Worker / student — work safely, use the protections provided, report hazards, incidents and near-misses, follow training, report defects you discover, and do not remove or defeat a safety device.

Client — disclose relevant health information, follow instructions for positioning and movement, and communicate discomfort or a change in condition promptly during treatment.

REMEMBER

- *Responsibility is shared, but it is not equal — accountability rises with authority.*
- *As a student on placement you are a worker under OHS law. The duties and the rights both attach to you from day one.*
- *Self-employed RMTs wear every hat at once: employer, supervisor and worker are the same person.*

Module 2 · The three fundamental worker rights

The right to KNOW — to be informed about the hazards in your workplace and trained to handle them safely, including every WHMIS-controlled product, the location of its SDS, and the procedures that apply. This right is the reason WHMIS exists.

The right to PARTICIPATE — to take part in keeping the workplace safe, through a joint health and safety committee or representative, by asking questions, raising concerns, and taking part in inspections and investigations without penalty.

The right to REFUSE — to refuse work you reasonably believe is dangerous to yourself or another worker, following the legislated refusal process. The belief must be reasonable; it does not have to be proven correct in advance.

The refusal process runs: (1) stop the work and stay at the workplace in a safe place — refusing is not leaving; (2) promptly report the refusal and the reason to your supervisor or employer; (3) the employer or supervisor investigates in your presence, and with a worker health and safety representative where one exists; (4) the matter is resolved and work resumes, or the refusal continues on reasonable grounds and a government inspector is contacted; (5) the inspector investigates and issues a written decision, which binds the parties.

REMEMBER

- *These rights are legislated, not granted by your employer. They cannot be signed away in a contract.*
- *A refusal may not be used as grounds for reprisal. Know your clinic's procedure before you need it.*
- *The refusal procedure differs by province — confirm the process that applies where you practise.*

Module 3 · WHMIS 2015 — the three pillars

WHMIS is Canada's national standard for communicating chemical hazards. WHMIS 2015 aligns with the globally harmonized system (GHS), which standardized hazard classes, pictograms, signal words and a 16-section Safety Data Sheet.

Labels — identify the product, its hazards and its precautions at a glance, on the container, at the moment of use. The label is the only part of the system present at the point of decision.

Safety Data Sheets — 16 sections in the same order for every product, providing handling, storage, first-aid, exposure-control and emergency information; must be readily accessible to every worker on every shift, including the student on placement.

Education & training — workers must be trained to read labels and SDSs and to handle, store, use and dispose of each product safely. Training is the employer's duty and must be current and site-specific.

REMEMBER

- *WHMIS = Labels + SDS + Training. Remove any one pillar and the system fails.*
- *WHMIS is not just for factories. A spray bottle of disinfectant is a WHMIS product, and there is no small-clinic or self-employment exemption.*

Module 3 · Supplier labels vs. workplace labels

Supplier label — applied by the manufacturer or importer on the original container. Six elements: product identifier; pictogram(s) for each hazard class; signal word (Danger or Warning); hazard statement(s); precautionary statement(s) covering prevention, response, storage and disposal; and the supplier identifier (name, address, telephone).

Workplace label — used when a product is decanted, or when the supplier label is lost or illegible. Three elements: product identifier matching the SDS name exactly; safe-handling precautions; and a reference to the SDS.

Where clinics fail: the unlabelled spray bottle; the faded label (alcohol destroys printed labels — a label that cannot be read is legally no label); the improvised container (never store a chemical in a food or drink container); the wrong or unrecorded dilution; the missing SDS; and the mixed product (topping up an old bottle with a different cleaner creates unknown chemistry and voids every label claim).

REMEMBER

- *If a container isn't clearly labelled, don't use it — confirm the contents and label it first.*
- *Never leave a container unlabelled, even for one shift. It takes ten seconds and a marker, and an unlabelled bottle denies a colleague their statutory right to know.*
- *Every one of these failures is a citable OHS violation, and every one is preventable.*

Module 3 · Navigating the Safety Data Sheet

Sections 1–8: (1) identification; (2) hazard identification; (3) composition/ingredients; (4) first-aid measures; (5) fire-fighting measures; (6) accidental release measures; (7) handling and storage; (8) exposure controls / PPE.

Sections 9–16: (9) physical and chemical properties; (10) stability and reactivity; (11) toxicological information; (12) ecological information; (13) disposal considerations; (14) transport information; (15) regulatory information; (16) other information, including the revision date.

You are not expected to memorize all 16 sections. You are expected to navigate them: sections 4, 7 and 8 are the everyday ones.

REMEMBER

- *Splash in an eye → section 4. Where do I store it → section 7. Do I need gloves → section 8. Can I mix it → section 10. Is this sheet still current → section 16.*
- *An SDS that is years out of date may no longer describe the product in your hand.*

Module 3 · Hazardous products in a massage clinic

Surface & equipment disinfectants — read the contact (wet) time and the dilution; ventilate; avoid skin and eye contact; never mix with another cleaner; confirm the product carries a Drug Identification Number (DIN) and suits the surface and the organisms of concern.

Isopropyl alcohol & hand sanitizer — highly flammable; store away from heat and ignition; cap tightly; keep only small volumes at the workstation; let hands dry fully before touching equipment or linens.

Massage oils, lotions & essential oils — allergy and slip hazards. Screen for nut, seed and fragrance sensitivities and record the product used. Essential oils are concentrated chemicals: they can sensitize, irritate and, in some cases, are flammable. 'Natural' is not a safety classification.

General cleaning agents — bleach and ammonia must never be combined; the reaction produces chloramine gas, toxic at low concentration in an enclosed treatment room. Store cleaning products securely away from clients.

REMEMBER

- *Two clinic-specific killers: mixing bleach with ammonia, and flammable alcohol stored near heat.*
- *Spilled oil is a major slip-and-fall source. Wipe it now, not at the end of the shift.*

Module 4 · The safe & sanitary practice setting

Cleanable surfaces — non-porous, intact table, floors and counters that can be disinfected between every client. Torn upholstery cannot be disinfected and must be replaced.

Climate & ventilation; lighting & layout — enough light to work, screen skin and clean safely, and clear pathways to prevent trips, especially for a client rising from the table.

Privacy & dignity — doors, screens, secure change space and draping that protect privacy at every point in the appointment.

Hand-hygiene access — a sink with soap and paper towel, or an alcohol-based hand rub, at the point of care, not down a corridor in another room.

Waste & linen handling — covered waste, dedicated containers for contaminated items, and clean and soiled linen stored separately and never transported together.

REMEMBER

- *The environment is the first and most passive layer of safety — it protects the client even on the day you are tired.*

Module 4 · Equipment maintenance & service records

Inspect tables, face cradles and bolsters for stability, secure fittings and wear before each clinic day. Test lift tables through their full range. Check stools and step stools. Replace cracked or torn upholstery. Verify hot stone, hydrotherapy and electrical devices including cords, plugs and thermostats. Confirm that adjustable components lock.

The log records: item and unique identifier ('Table 3', not 'the table'); date of inspection or service; what was checked, repaired or replaced; who performed the work and their signature; next service due date; items removed from use and why; and the date the item was returned to service, and by whom.

The log matters because it is required, it proves compliance to an inspector, insurer or the College, it survives staff turnover, it reveals patterns, and it protects you personally if a client is injured on equipment you did not own.

REMEMBER

- *Tag out and remove from service anything unsafe. Never 'just be careful with it' — an unsafe table must be physically prevented from being used, not merely mentioned to a colleague.*
- *The 'returned to service' line is the classic failure: an item tagged out and quietly put back.*
- *A simple dated log on a clipboard satisfies the standard. Elegance is not required; consistency is.*

Module 5 · Hazard vs. risk, and the hierarchy of controls

A hazard is anything with the potential to cause harm — a wet floor, a flammable liquid, an awkward sustained posture, an infectious client, a faulty table. Risk is the likelihood the hazard causes harm combined with how severe that harm would be. RISK = LIKELIHOOD × SEVERITY. The hazard is a fact; the risk is a judgment.

The hierarchy of controls, most to least effective: (1) elimination — physically remove the hazard; (2) substitution — replace it with something safer; (3) engineering controls — change the physical conditions, e.g. ventilation or a dispensing system that removes hand decanting; (4) administrative controls — procedures, training, signage, scheduling; (5) PPE — gloves, masks, eye protection, effective only if worn correctly, every time.

REMEMBER

- *The same hazard carries different risk depending on exposure: spilled oil beside the table is high risk; the same spill in a locked storeroom nobody enters is not.*
- *PPE is the LAST line of defence, not the first. Always reach upward for a more effective control before relying on gloves and masks.*
- *We can't always remove a hazard, but we can almost always reduce the risk it poses.*

Module 5 · The five-step risk assessment and documentation

(1) Identify hazards — walk the space and the workflow, including tasks you perform without thinking. (2) Decide who's at risk — clients, you, colleagues, cleaners, delivery staff, visitors, and who is most vulnerable. (3) Evaluate & control — rate likelihood × severity, then apply the hierarchy starting at the top. (4) Record findings — the hazard, the control applied, the person responsible, the date. (5) Review & update — after any change, incident or near-miss, and at set intervals.

Documentation that must exist: risk assessments and control plans; cleaning and maintenance logs; incident and near-miss reports; training and certification records with expiry dates. Records must be legible, dated, attributable to a named person, and retained for the period your jurisdiction requires.

REMEMBER

- *An undocumented assessment cannot be reviewed, audited or handed over. Step 4 is the step everyone skips.*

- *Risk assessment is continuous, not a one-time form. New product, new equipment, new service or new staff member — new assessment.*
- *If it isn't written, it didn't happen.*

Module 6 · Microbiology — organisms, flora and the chain of infection

Bacteria (e.g. Staphylococcus aureus) — part of normal skin flora, survive on surfaces for extended periods, some strains antibiotic-resistant. Viruses (e.g. influenza, SARS-CoV-2, herpes simplex, hepatitis) — enveloped viruses are relatively fragile and readily inactivated; non-enveloped viruses are far more resistant and demand a product proven against them. Fungi (e.g. tinea, Candida) — resilient, favour damp warm areas; spores survive ordinary cleaning. Protozoa & parasites (e.g. scabies, head lice) — transmitted by prolonged direct skin contact and infested linens.

Resident flora live in the deeper epidermis, hair follicles and sebaceous glands; they are difficult to remove, are not the target of routine hand hygiene, and rarely cause infection unless introduced into deeper tissue. Transient flora are picked up from the environment, equipment or another person's skin, sit loosely on the surface, cause most cross-contamination — and are easily removed. That removability is the entire basis of hand hygiene.

The chain of infection, six links: (1) infectious agent; (2) reservoir — where it lives and multiplies, e.g. the client, the table, the lotion pump, a damp towel; (3) portal of exit; (4) mode of transmission — direct skin-to-skin or indirect via linens, face cradles and hands; (5) portal of entry — broken skin, mucous membranes, a hangnail; (6) susceptible host.

REMEMBER

- *You do not need to defeat the pathogen. You only need to break one link.*
- *Hand hygiene breaks the mode of transmission — the easiest link to break, and the one most often left intact.*
- *Envelope status decides your product. A disinfectant that kills flu may do nothing to a non-enveloped virus.*
- *Skin integrity is part of hand hygiene: cracked, over-washed hands hold more organisms, not fewer.*

Module 6 · Biofilms, fomites, and cleaning before disinfection

A biofilm is a community of microorganisms adhering to a surface under a protective matrix — inside a poorly cleaned oil bottle, a lotion pump, a hydrotherapy line or a footbath. Organisms in a biofilm are dramatically more resistant to disinfectants; once established, a biofilm must be physically removed. Spraying it does not work.

Fomites are inanimate objects that carry infection: linens, face cradles and covers, bolsters, pillows, clipboards, pens, door handles, light switches, payment terminals and phones. The highest-risk items are the ones touched between clients with contaminated hands.

Aseptic technique: (1) cleaning — removing visible soil and organic matter with detergent and friction; it does not kill organisms, it removes the shield that protects them; (2) disinfection — killing most pathogenic organisms on inanimate objects; (3) sterilization — killing all microbial life including spores, rarely required in massage therapy.

Standard precautions (routine practices): treat all blood, body fluids, secretions, excretions and non-intact skin as infectious, for every client, every time, regardless of what you know or assume about that person's health status.

REMEMBER

- *Organic matter shields microbes from a disinfectant — you cannot disinfect through a film of massage oil, however good the product. Clean first, always.*
- *Contact time is the period a surface must remain visibly wet for the product to kill what its label claims. Spraying and wiping immediately achieves nothing.*
- *Clinics must use hospital-grade disinfectants carrying a Drug Identification Number (DIN).*

- *Why 'every client, every time'? Because infectivity often precedes symptoms — and because the alternative is guessing about people.*

5. Content review — Lecture 2

LECTURE 2 · DAY 2 — THE CLIENT

Module 7 · Routine practices and the point-of-care risk assessment

Routine (standard) practices mean treating every client and every body fluid as potentially infectious, regardless of known diagnosis. You cannot tell who is infectious by looking, and the client may not know their own status.

The four components: a point-of-care risk assessment before each interaction; hand hygiene at the right moments; appropriate PPE for the assessed risk; and a clean environment and equipment between every client.

The PCRA is three questions: (1) What is the task? (2) What is my risk of exposure — to non-intact skin, blood or body fluids, mucous membranes, or a contaminated surface? Is a splash plausible? (3) What controls does that require — hand hygiene always, then, proportionate to the risk: gloves, a mask, eye protection, a modified technique, or deferral of the treatment.

Which practice breaks which link: infectious agent → cleaning and disinfection with a DIN product proven against the organism; reservoir → fresh linens every client, disinfected table, bolsters and face cradle, no biofilm in oil bottles; portal of exit → cover your own wounds, respiratory etiquette, do not treat over an open lesion; transmission → hand hygiene at the four moments, gloves where indicated, no shaking of soiled linen; portal of entry → do not treat non-intact skin, keep your own skin intact, avoid touching your face, PPE where splash is possible; susceptible host → screen and re-screen, defer where indicated, extra care for pregnant, older and immunocompromised clients.

REMEMBER

- *The PCRA is a habit of thought, not a form. It is what makes PPE a decision rather than a reflex.*
- *Selective application of precautions is both unsafe and discriminatory.*

Module 8 · Hand hygiene — the four moments

Moment 1 — BEFORE client contact: protect the client from germs on your hands. Moment 2 — BEFORE a clean or aseptic task, e.g. applying a dressing to broken skin. Moment 3 — AFTER body-fluid exposure risk: any contact with fluids, wounds or mucous membranes. Moment 4 — AFTER the client and their surroundings.

Across one 60-minute appointment the moments recur far more often than students expect: after handling the clipboard and before touching the client; on re-entering the room after the client undresses; after adjusting a bolster or touching the face cradle, before returning to skin; immediately after any fluid contact; and after stripping the table and handling soiled linen, even if gloves were worn.

REMEMBER

- *Hand hygiene is the single most effective measure to prevent transmission in any health-care setting — and the practice most often skipped when a clinic runs late.*
- *If you performed hand hygiene twice in an appointment, you missed moments.*

Module 8 · Soap vs. alcohol-based rub, technique, and 'bare below the elbows'

Soap & water — when hands are visibly soiled with dirt, oil or body fluids; after using the washroom; before eating; and when exposed to certain spore-forming germs. Lather 15–20 seconds covering all surfaces, and dry thoroughly with a clean paper towel. Oil and lotion count as visible soil, which is why soap and water arise more often in massage than in some other settings.

Alcohol-based rub — when hands are not visibly soiled, which is most situations in practice. Use enough product to cover all surfaces and rub until completely dry, roughly 20–30 seconds.

Technique — the five things people miss: enough product; all surfaces (palms, backs, between every finger, thumbs, fingertips and nail beds, wrists — fingertips and thumbs are most commonly missed and most used in massage); full duration; drying properly (wet hands transfer organisms far more readily than dry hands; use the towel to turn off a manual tap); and protecting your skin.

Bare below the elbows: short sleeves, no rings, no wristwatch or bracelets, and short natural nails — no gel, no extensions, no chipped polish. All of them harbour organisms and all of them prevent product reaching the skin.

REMEMBER

- *This is a practice rule, not a dress preference, and it applies from the moment you enter the treatment area.*
- *Dermatitis is an occupational injury and should be reported, not concealed. Protecting your hands is a professional obligation, not vanity.*

Module 8 · PPE — selection, donning and doffing

Gloves — when contact with broken skin, body fluids or contaminated items is likely; perform hand hygiene before and after. Mask — when respiratory illness is present, droplets are possible, or public-health guidance directs it. Eye protection — where splashes or sprays to the face are possible. Gown or apron — when clothing may be contaminated.

Donning, before contact: hand hygiene first; gown or apron fastened at the back; mask secured over nose and mouth and moulded to the nose; eye protection positioned; gloves last, over the gown cuff. Do not adjust PPE once you begin the task.

Doffing, after contact: gloves first — the most contaminated item; hand hygiene; gown rolled away from the body, contaminated side in; eye protection handled by the arms or strap, not the front; mask last, by the ties or loops, never the front; hand hygiene again.

REMEMBER

- *The principle behind the order: the outside front of every item is contaminated. Remove the dirtiest item first, and touch only the parts that stayed clean.*
- *Gloves supplement hand hygiene — they never replace it. Hands become contaminated during removal, and gloves can have unseen defects.*
- *Self-contamination during removal is the most common PPE failure in every health-care setting. Single-use PPE is never reused, never washed, never pocketed.*

Module 9 · Spaulding classification and disinfecting between clients

Non-critical — contacts intact skin only; requires cleaning plus low-level disinfection; covers the table, bolsters, face cradle frame, stones and your hands. Semi-critical — contacts non-intact skin or mucous membranes; requires high-level disinfection; rarely applicable in massage therapy. Critical — enters sterile tissue or the bloodstream; requires sterilization; not within massage therapy scope.

Definitions: clean = remove visible soil and organic matter; disinfect = kill most pathogenic organisms on an inanimate object; sterilize = kill all microbial life, including spores.

Applied to what you actually touch: the table, bolsters and face cradle frame are cleaned and low-level disinfected between every client; oil and lotion containers and pumps are the classic biofilm site — never top up a bottle; linens and covers are single-client use and are laundered, not disinfected; high-touch non-clinical surfaces (door handles, light switches, payment terminal, pens, clipboards, phone) are routinely forgotten between clients.

The room reset, in order: (1) clean first — remove visible soil and oil; (2) apply a DIN-carrying disinfectant over the whole surface, not just the visible middle; (3) respect the contact time; (4) target high-touch points; (5) let dry, place fresh linens, and perform hand hygiene before touching anything clean.

REMEMBER

- *If it touched a client and it cannot be laundered, it must be cleaned and disinfected before the next one.*
- *The oil bottle and the payment terminal are the two items students never think of.*

Module 9 · Contact time — the step that decides everything

Contact time (wet time, dwell time) is the period the surface must remain visibly wet with the product for the kill claim on the label to be achieved. It is the condition under which the product was tested and licensed — not a suggestion.

Read it, don't assume it: contact times vary by product and by organism, from under a minute to ten minutes, and two bottles that look identical may differ. The time is on the label and in SDS section 7.

Use enough product to stay wet: if the surface dries before the time elapses, the claim is void. In a warm room, on a large table, that means re-application — not a harder wipe. And contact time on a soiled surface is wasted time.

Time it honestly: the pressure to reset a room in ninety seconds is the single biggest driver of IPAC failure in private practice.

REMEMBER

- *A disinfected room takes as long as the label says. If the schedule doesn't allow it, the schedule is the hazard.*
- *A booking schedule with no turnover time is an administrative control failure, not a therapist failure.*
- *This is the most commonly failed practical item in the course.*

Module 9 · Linen handling

Fresh linens for every client — clean sheets, face-cradle covers and bolster covers, with no exceptions and no reuse for a family member.

Handle soiled gently — do not shake soiled linens; shaking aerosolizes skin cells and organisms into the room you have just disinfected. Roll the linen inward on itself and place it directly into a covered hamper.

Wash separately and hot — launder contaminated linens separately, on the hottest setting the fabric allows, and dry completely. Damp linen is a reservoir.

Separate clean and soiled in storage and transport; perform hand hygiene after touching soiled linen even if gloves were worn; and never re-use a cover.

REMEMBER

- *Never shake soiled linen. It is the fastest way to turn a clean room back into a contaminated one.*
- *A clean stack carried under the same arm as a soiled bundle is now a soiled stack.*
- *'It looks clean' is not a standard. Single-client use is the standard.*

Module 10 · Communicable disease — you, and the client

If you are unwell: defer or refuse treatment where you have a communicable disease that no barrier can contain — this is expressly permitted and expected. Stay home with fever, vomiting or diarrhoea; do not treat and do not attend the clinic. Cover cuts with waterproof dressings before you arrive. Keep immunizations up to date — hepatitis B vaccination is

strongly recommended for health-care providers including massage therapists. Follow the directives in force. Notify the clinic promptly so appointments can be rescheduled.

If the client is unwell: screen for symptoms before the appointment — at booking, at confirmation and again on arrival. Reschedule active, transmissible infections rather than draping around them. Apply extra precautions where appropriate. Disinfect thoroughly afterwards with full contact time. Notify and document if others may have been exposed, and report where reporting is required.

REMEMBER

- *Working while infectious exposes every client you see that day, and a massage therapist cannot distance from the client.*
- *Declining care to protect others is a professional duty, not a failure — and it is never grounds for reprisal.*
- *Rescheduling a sick client protects the six clients who follow them into that room.*
- *Screening after the client is on the table is too late.*

Module 10 · Blood-borne pathogens, exposure response and waste

Blood-borne pathogens (hepatitis B, hepatitis C, HIV) spread through contact with infected blood or body fluids. Massage rarely involves blood, but cuts, hangnails, scratched lesions, nosebleeds and unexpected wounds do occur. A hangnail on your finger and a scratched lesion on the client are a portal of exit and a portal of entry facing each other.

Exposure response, five steps: (1) stop and cover — stop treatment immediately, cover any wound on you or the client; (2) wash the area with soap and water immediately, flush eyes with water if splashed — do not scrub, squeeze or apply bleach to the wound; (3) clean and disinfect the surfaces involved and dispose of contaminated items as regulated waste; (4) report to your supervisor or clinic and seek medical assessment promptly — timing matters for post-exposure follow-up; (5) document the facts and actions in an incident report.

Waste: general waste in lined, covered bins; biohazardous waste (items soaked with blood or body fluids) in designated containers, never in the general bin or the linen hamper; sharps directly into a puncture-proof container, never loose in the trash and never recapped by hand; chemical disposal per the SDS (section 13) and local rules — never pour concentrates down the drain.

REMEMBER

- *You will not know a client's status and neither may they. Routine practices are what protect you — not a health-history question about infection status.*
- *Rare is not never. The response must be rehearsed before the day you need it.*
- *Know the escalation path for the rare biohazard or sharp before it appears.*

Module 11 · Informed consent

Consent is a continuous conversation, not a one-time signature. Explain and discuss the proposed treatment, the areas to be worked, expected sensations and any risks — including public-health risks where relevant. Obtain voluntary consent from a client with capacity. The client may refuse, modify or stop treatment at any time, regardless of prior consent, without justifying the decision.

In practice: consent at booking and intake, before the client is undressed on a table; confirm the plan, areas, pressure and draping before treatment begins, naming any sensitive area plainly and recording the answer; check pressure, comfort and warmth during treatment; obtain new consent when the plan changes; and document what was explained, what was agreed and any concern raised.

Sensitive areas include the chest and breast, the gluteal region, the groin and the abdomen — treat the list as a floor, not a ceiling. Specific consent is required for that area, at that visit, and must be documented.

REMEMBER

- *Silence is not consent. Watch for withdrawal, guarding, breath-holding and silence — the client may not feel able to speak up.*
- *There is no implied consent for the gluteal region because the client booked a 'full body' massage.*
- *The client's vulnerability never diminishes with familiarity. A long-standing client is not a lesser consent obligation.*
- *Consent that is not documented is difficult to demonstrate later.*

Module 11 · Draping, boundaries, screening and safe positioning

Draping: keep the client covered at all times and expose only the area being treated, only while it is being treated; re-drape before moving on; allow dressing and undressing in private with the door secured; use secure draping for turning — the drape is held and controlled by you through the turn, never left to the client.

Contraindications, three categories: absolute — do not treat, e.g. acute systemic infection; refer. Local — avoid a specific area, e.g. an open wound, an acute injury or varicose veins, but treat elsewhere; the area is excluded, the client is not. Relative / conditional — treat with modification and, where needed, physician clearance.

Re-screen at every visit: health status changes between appointments — new medications, a new pregnancy, a recent injury, a new diagnosis, a fever that started this morning. The intake form is a snapshot; the re-screen is the practice.

Positioning and falls: support and bolster; assist on and off with the table lowered and a step stool; plan transfers and ask before assisting; guide turns; clear the floor of oil, cords and bags; and let clients rise slowly — stay in the room.

REMEMBER

- *Draping is both a dignity measure and an abuse-prevention measure. It protects the client, and it protects you.*
- *Falls getting on and off the table are the most common client incident in massage therapy.*
- *The client is warm, relaxed, barefoot and possibly hypotensive — treat the last two minutes of the appointment as the highest-risk two minutes.*
- *When in doubt, don't. Treating beyond your competence — or against a contraindication — is unsafe and unethical. Refer.*

Module 12 · Public health, outbreak management and safety culture

The RMT's public health role: a gatekeeper in the primary health-care system who sees clients more frequently and for longer than most physicians; identifying and reporting communicable diseases where required; and maintaining a sanitary environment to prevent community spread.

Standard 5 — risk identification and management: outbreak management (following the directive in force when a public health risk is identified — enhanced screening, masking, altered scheduling, temporary closure or suspension of services, promptly); screening tools (standardized questionnaires applied to everyone are more reliable and more defensible than memory and intuition); and exclusion criteria (defined in advance, applied consistently, communicated at booking so the decision is a policy, not an argument at the front desk).

Quality and safety culture: continuous professional development in health and safety; evidence-informed practice using current public health data — not habit, not what the clinic has always done, not what a supplier claims; and a clinic where incidents are reported and analyzed without blame.

REMEMBER

- *Public health is not just about the individual in front of you; it is about the community they return to.*

- *Blame produces silence, and silence produces repetition.*
- *Safety is a competency, not a checklist.*

6. Content review — Lecture 3

LECTURE 3 · DAY 3 — THE THERAPIST AND THE RESPONSE

Module 13 · Occupational hazards and musculoskeletal injury

Four hazard categories for the therapist: musculoskeletal (repetitive strain to hands, wrists, thumbs, shoulders and back — the leading hazard of the profession and the one most likely to end a career); physical fatigue (long hours of sustained pressure and standing; fatigue degrades body mechanics, which accelerates injury); psychosocial (emotional labour, isolation and stress building toward burnout — a hazard in law, not merely a feeling); and exposure (skin conditions, body fluids and contaminated linens, seen from the therapist's side).

Why therapists are at risk: sustained force, repetitive motions, awkward postures and few rest breaks — all four present in a single treatment hour, compounding across a schedule. Common sites: thumbs and wrists (de Quervain's tenosynovitis, carpal tunnel syndrome), shoulders, neck and lower back.

Early warning signs: aching, tingling, weakness or numbness that lingers after work. Symptoms that persist overnight, or appear earlier in the day each week, are the signal. Report symptoms, modify technique and seek care early.

REMEMBER

- *Most therapist injuries are cumulative and preventable — they develop slowly and respond well to good habits early.*
- *Pain is a signal, not a weakness. Early reporting protects the career; silence ends it. Never push through pain.*
- *Reporting is a duty under the Internal Responsibility System, not an admission of weakness.*

Module 13 · Body mechanics and sustainable practice

Stack & align — ears, shoulders and hips stacked; a neutral spine beats a bent back. Lunge & shift — generate pressure by shifting body weight through a lunge, not by pushing with the arms; pressure comes from the floor, through the legs. Save your thumbs — use forearms, elbows, fists and supported hands; the thumb is a precision tool, not a pressure tool. Stay close — work within your base of support; reaching multiplies the load on your shoulder and back.

Set-up: table height set so you can apply pressure with a straight back and slightly bent elbows, adjusted per client and per technique; feet shoulder-width in supportive flat shoes with room to move around the whole table; position square to the area rather than reaching or twisting; use a stool for seated work and bolsters to bring the client to you.

Sustainable practice: strengthen and stretch as an athlete would; pace the schedule with breaks, a capped daily load and no back-to-back heavy deep-tissue work; recover deliberately through rest, hydration, sleep and your own bodywork; and vary your work so no single joint takes the full load repeatedly.

REMEMBER

- *Table height is the master variable. Too low is the most common cause of back strain in new therapists — and the adjustment takes six seconds.*
- *Varying your techniques and tools across the day is an engineering control on your own body.*
- *Turnover time is also contact time for disinfectant — the schedule serves two safety purposes.*
- *Self-care is professional maintenance, not indulgence. Your hands are the practice.*

Module 14 · Workplace violence, harassment and boundaries

Health and safety law requires employers and practitioners to recognise and prevent violence and harassment — including from clients. The forms include physical aggression, threats, sexual advances, sexualised comments or requests, and verbal or online harassment. Harassment does not require intent, and it does not require a witness.

Prevent and screen: clear policies, intake screening, a safe room layout, and a known way to summon help — a phone within reach, a colleague nearby, a door you can reach without passing the client.

Respond safely: end the treatment, remove yourself, and never tolerate sexualised or threatening behaviour. You do not owe the client the remainder of the hour, an explanation, or a refund negotiation in that moment. Then document factually, report per policy, and access support.

What to write down: the date and time; what was said or done in the person's own words as closely as you can recall; what you said and did in response; who else was present or informed; and what happened next. Write it the same day. Do not editorialize and do not minimize it.

De-escalation: stay calm with a steady tone and open posture; listen and acknowledge the concern without arguing; set a clear, respectful limit on the behaviour; give space and an exit; disengage and get help if safety is at risk.

REMEMBER

- *Client misconduct is never the therapist's fault — and you are entitled to a safe working environment.*
- *The legal right to refuse unsafe work applies here, and clinic policy cannot override a statutory right.*
- *Rehearse the wording for declining an inappropriate request before you need it, because in the moment you will say what you have practised. Safety comes before politeness, always.*

Module 14 · Stress, fatigue and burnout

Chronic stress is an occupational hazard. A fatigued therapist makes poorer decisions about pressure, screening and consent.

Recognise burnout: exhaustion, cynicism, dread before work, and a reduced sense of accomplishment. It develops gradually and is easiest to address early.

Build support: peer networks, supervision, mentorship and professional counselling reduce isolation — solo practice is professionally isolating by design, so the network must be built deliberately. Protect work–life balance: sustainable hours, boundaries with clients, and time genuinely off.

REMEMBER

- *A schedule with no margin is a hazard, not a work ethic.*
- *Burnout is a systemic and personal-health issue, not a character flaw. Help-seeking is a professional competence, in exactly the same way that reporting a hazard is.*
- *If any of this feels personally relevant, reaching out to a professional or a trusted person is a sign of strength. Ask your instructor about the student-support pathway.*

Module 15 · Emergency preparedness and medical emergencies

Prepared before it happens: a written plan everyone has read and can follow under pressure; ready equipment (a stocked first-aid kit checked on a schedule, accessible exits, current first-aid/CPR certification); known contacts (emergency numbers, the clinic address and the nearest medical facility, posted); and practice and review.

Common medical emergencies: fainting or dizziness — often when getting off the table after lying prone and warm; help them lie down, elevate the legs, loosen tight clothing, and let them recover slowly. Allergic reaction — stop, remove the

product, wash the area, and call for help if breathing is affected. Cardiac or breathing distress — call emergency services, begin CPR if trained and needed, use an AED if available. Seizure, low blood sugar, asthma — keep the person safe, do not restrain, protect the head, follow the plan.

The universal sequence: CHECK (scene safe? responsiveness and breathing — protect yourself first, you cannot help anyone if you become the second casualty); CALL (call emergency services, or direct a specific named person to call, and get the AED); CARE (CPR if trained and needed, control bleeding, treat for shock, reassure — within the limits of your training); HAND OVER (stay until help arrives, report what happened and the care given, then document).

REMEMBER

- *Preparation turns panic into procedure — under stress, people fall back on what they have practised.*
- *'Someone call 911' means nobody calls. Point at a specific person and give them the task.*
- *Ensure scene safety, call for help early, stay within your training, and never leave the person alone.*
- *This course is awareness only — it does not replace certified hands-on first-aid and CPR training.*

Module 15 · Fire safety and evacuation

Prevent and prepare: keep exits clear and marked; maintain extinguishers and smoke alarms and record the checks in the service log; store oils, linens and chemicals safely — alcohol-based products are flammable and linens are fuel; know the location of alarms, extinguishers and utility shut-offs in every room you work in; post the evacuation route; include fire in the written plan and the drill schedule.

If you must evacuate: (1) raise the alarm and stay calm — your calm is the client's information about how serious this is; (2) help the client dress only if time allows — a drape or a robe is enough; (3) leave by the nearest safe exit and do not delay for belongings, treatment notes or the appointment book; (4) never use elevators, and assist anyone who needs help — plan in advance for clients with mobility limits; (5) meet at the assembly point and account for everyone, including clients who were in treatment rooms and may not have heard the alarm; (6) call emergency services and do not re-enter.

REMEMBER

- *A massage clinic contains flammable liquids, textiles and heat sources in a small space with an undressed, prone client.*
- *Client modesty matters — but never at the cost of safety. Life over property, and life over dignity if it comes to it.*
- *Re-entering to check a room is how responders lose people. Someone must be assigned in the plan, in advance, to check every room.*

Module 16 · Incident management and investigation

Respond, five steps: (1) make safe — care for the person and remove any ongoing hazard; the hazard first, then the paperwork; (2) get help — escalate early rather than late; (3) record — document facts (what, when, who, action taken) promptly and objectively; facts, not conclusions or blame; (4) report — notify your supervisor and follow internal procedures; near misses are reported too; (5) review — investigate the cause and put changes in place.

Root-cause thinking: gather the facts soon after the event while memory is fresh; ask why repeatedly (the '5 Whys') to trace beyond the immediate cause to the underlying system gap; fix the system using the hierarchy of controls; and verify the corrective action actually reduced the risk.

The worked example: the therapist slipped → on spilled oil → not wiped → no cloth in the room → no restock routine. That last one is the cause worth fixing.

Reporting destinations: supervisor/clinic for every incident and near-miss; the health and safety authority for a serious or critical workplace injury; your regulatory College for conduct and safety matters including mandatory reports, sexual abuse and incapacity; public health for certain communicable diseases. Specifics vary by province.

REMEMBER

- *Incident reports are not about blame — they protect the client, support learning and document your professional response.*
- *The near-miss is the free lesson. Document at the time, not from memory later.*
- *'The therapist slipped' is not a cause; it is where the investigation starts. Retraining an individual is an administrative control — one of the weakest available.*
- *When unsure whether something is reportable, ask your regulator — 'I didn't know' is not a defence.*

Module 17 · A culture of safety, audits and improvement

Speak up — hazards and near misses are raised without fear of blame, and concerns are acted on. A report that produces nothing teaches everyone not to report. Shared ownership — from owner to student, safety is part of everyone's role under the IRS. Keep learning — ongoing training, updated policies and current certifications. Lead by example — students copy what they see, not what the policy says.

The improvement loop: PLAN a schedule of self-inspections, equipment checks and IPAC audits; CHECK by walking through with a checklist and observing practice as well as reviewing records — watch what people do, not what they say they do; ACT to fix gaps, update procedures, retrain and document corrective actions, applying the hierarchy of controls; REPEAT on a cycle.

REMEMBER

- *Safety is not a binder on a shelf — it is a shared daily habit.*
- *Small, regular improvements compound into a genuinely safe practice. A strong safety culture is exactly what CMTCA accreditation looks for.*

Module 18 · WHMIS in practice — a working refresher

Why it applies here: federal and provincial legislation requires all workers exposed to controlled products to be trained — no small-clinic and no self-employment exemption; CMTCA expects the educational environment and clinical placement to meet OHS laws; and applying health and safety protocols according to applicable legislation is a competency you are assessed against.

Common clinic hazards: disinfectants (hydrogen peroxide, isopropyl alcohol, bleach — corrosives and irritants); lubricants (essential and carrier oils — some flammable, many skin sensitizers); cleaning supplies (floor cleaners, laundry detergents — respiratory exposure in a small, poorly ventilated room); compressed gases (oxygen tanks in multidisciplinary settings — store upright and secured away from heat).

Standard 5 in the treatment room: storage — hazardous materials stored away from client treatment areas, out of reach of a child or a confused client; disposal — municipal and provincial bylaws for hazardous waste, never concentrates down the drain; spill procedures — know before the spill what absorbs it, what PPE you need, how to ventilate, and who to tell.

Reach up the hierarchy first: substitution (a less toxic disinfectant that still achieves the required kill and carries a DIN) → engineering (ventilation, a dispensing system that removes hand decanting) → administrative (training, signage, written dilution procedures, scheduling chemical work away from client contact) → PPE (gloves or goggles when mixing concentrates). Elimination sits above all of these.

REMEMBER

- *'Natural' is not a safety classification — concentrated plant chemistry is still chemistry.*
- *A spill is a slip hazard, a chemical exposure and a respiratory hazard at once — three hazards from one bottle.*
- *WHMIS is a living system: an SDS binder assembled three years ago and never opened is not compliance, it is a prop.*

7. Content review — Lecture 4

Confirm with your instructor whether Lecture 4 is within the examinable scope for your cohort before relying on this section.

LECTURE 4 — THE COMMUNITY

Module 19 · Community support — a professional obligation

Community support is not optional, not a marketing activity, and not something you earn the right to skip by being busy. It is a duty that follows from being a regulated health professional: regulation is granted in exchange for a promise of public protection, and public protection does not stop at the treatment-room door.

It belongs in a health and safety course because community harm is still harm: a missed referral, an unchallenged piece of misinformation, an inaccessible clinic or an unreported suspicion of abuse each injure real people.

Two competencies sit behind it: collaborating with other health care professionals (isolation causes harm — missed contraindications, duplicated treatment, contradictory advice) and promoting health and wellness within the community (your access to the public carries responsibility).

The goal is that massage therapy be safe (does not harm the people who use it or the community around it), integrated (part of the health care system rather than adjacent to it), and accessible (available to the people who need it — not only to those who can climb the stairs, afford the fee, understand the intake form, or feel safe in the room).

The social determinants of health — income, housing, employment, education, food security, social support, discrimination and access to services — shape who becomes injured, who recovers, and who ever reaches a massage therapist. They explain your caseload, non-attendance, and why treatment plans that ignore a client's circumstances fail.

REMEMBER

- *A profession can be perfectly safe and still fail the community, by being unreachable or unaffordable.*
- *The pain is individual; the pattern is not.*

Module 20 · The circle of care, consent to disclose, and referral

The circle of care is the group of health care providers involved in a client's care, who may share relevant information with one another for the purpose of providing that care. It is not permission to discuss a client freely with anyone in health care: it is limited to those involved in that client's care, for that purpose, with the client's knowledge and consent.

'With consent' governs all of it: consent to treat is not consent to disclose. Ask specifically — name who you want to contact, what you want to share and why. Share only what is relevant; the purpose defines the scope. Document what you asked, what was agreed, what you sent, to whom and when. Respect a refusal — the response to a refusal is a clinical decision, never pressure.

The safety purpose is concrete: preventing contraindications by sharing relevant health information. Clients omit things not from dishonesty but from not knowing they are relevant — a new anticoagulant, a recent imaging result, a change in a cardiac medication.

When to refer: clinical scope (undiagnosed pain, red-flag symptoms, suspected fracture, a mole that has changed, unexplained weight loss); competence within scope (a technique, population or condition you have not been trained for — scope and competence are different limits and both bind); psychosocial need (distress, disclosure of abuse, suicidal ideation, addiction, housing crisis); and sustained non-response.

Safe referral: know the resources before you need them; make it warm — give a name, a number and the first step, and offer to make the call; match urgency to the pathway; follow up at the next visit; and document what you observed, advised, provided and what the client decided.

REMEMBER

- *The client is in the circle, not the subject of it. Nothing is discussed behind them.*
- *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. A crisis is not a business card.*
- *Referral is not an admission of inadequacy. It is the clearest evidence that you know what you are doing.*

Module 21 · Advocacy, misinformation and health promotion

The RMT is one of the few health professionals the public sees regularly, at length, and relaxed enough to ask questions they would never take to a physician. What you say is received as professional advice whether or not you framed it as an opinion. Be evidence-informed rather than opinion-informed, know the edge of the evidence, and stay in your lane: musculoskeletal health, ergonomics, load management, stress and recovery are yours; nutrition, medication and diagnosis are not.

Correcting misinformation: (1) lead with the accurate information — corrections that begin with what is wrong invite an argument; (2) don't repeat the false claim more than you must, because familiarity feels like truth; (3) explain why, briefly; (4) don't shame the person — contempt ends the conversation and the therapeutic relationship; (5) refer where it matters — if it concerns a diagnosis, a medication or a serious condition, the correction is a referral; (6) know when to stop — you are not obliged to win, you are obliged to be accurate.

Community education — workshops on ergonomics, stress management and injury prevention reach people who will never book an appointment. Two cautions: a workshop is education, not treatment (do not assess, diagnose or treat individuals in a room hired for a talk); and a session that functions primarily as client acquisition is marketing, which must not be presented to the community as something else.

In a public health crisis: follow the directives in force; be a reliable channel by directing people to public health guidance and their own prescriber; model it visibly through screening, masking where directed and deferring treatment when unwell; and know the limits of your role — you are not a vaccination service, an epidemiologist or a public health authority.

REMEMBER

- *'I don't know, but I know who would' is a complete professional answer.*
- *The hardest misinformation to correct is the flattering kind that is told about your own profession.*
- *Trust is the mechanism. A client who feels judged simply stops telling you what they are doing — and a client who conceals what they are doing is a client you can no longer screen.*
- *A regulated professional's public statements are not private speech.*

Module 22 · Cultural safety, trauma-informed care and accessibility

Cultural safety shifts the question from what you know about a group to how the client experiences the encounter. It is not a checklist of cultures — attempting to learn facts about every community produces stereotyping. It requires self-reflection first, recognising that you carry the authority in the room, and asking rather than assuming. Only the client can say whether the encounter was safe.

Trauma-informed care asks 'what has happened to this person', not 'what is wrong with this person'. Trauma is common enough that you will treat survivors regularly without knowing it, so the approach is universal — exactly like routine practices. Massage is a high-risk setting: undressing, lying prone, being touched by a stranger with authority whom you

cannot see. The response may not look like distress — freezing, going quiet, agreeing to everything, dissociating, being unable to say stop.

In the room: predictability (say what you are about to do before you do it — no touch a client has not been told is coming); control stays with the client; consent that can actually be exercised (check in actively rather than asking the client to interrupt an authority figure); read the body; and an environment with the door secured, private changing, adequate drape and warmth. If there is a disclosure: listen, do not probe, thank them, ask what they need now, and refer.

Accessibility: physical (steps, no lift, a heavy door, no accessible parking or washroom; a table that lowers, a step stool, space to transfer), communication (plain-language forms, interpreters, alternative formats), and sensory/cognitive (lighting, noise, scent — a scent-heavy waiting room excludes clients with migraine, asthma and chemical sensitivity). Financial accessibility is the uncomfortable one: the people with the most musculoskeletal injury often have the least benefit coverage.

REMEMBER

- *'Compliance is not consent' is the single most important sentence in this module. Stillness is not comfort.*
- *Trauma-informed does not mean trauma-treating. Your job is to make the encounter safe and to refer.*
- *A client who does not feel safe does not disclose — and a client who does not disclose cannot be screened.*
- *Legislation sets a floor; the professional obligation is to ask honestly who your clinic currently excludes. Individual measures such as sliding scales help, but structural barriers require structural responses.*

Module 23 · Ethical engagement — boundaries, conflict of interest, mandatory reporting

Boundaries in community and volunteer work: the setting changes, the relationship does not. A tent is a treatment room — consent, draping, screening, hand hygiene, records and scope apply identically. The hardest parts are the ones that get dropped: screening in a queue of forty, draping in an open marquee, hand hygiene with no sink, records with no chart. If you cannot do them, you cannot treat there — change the set-up or decline. Dual relationships multiply in community work; decide the boundary in advance.

Conflict of interest is a situation, not a character defect. Watch for sponsorship and endorsement, education used as client acquisition, reciprocal referral arrangements, and recruiting from people in distress. The test: would this arrangement change my clinical advice? Would the client be surprised to learn of it? If either answer is yes, disclose it or decline it.

Mandatory reporting: suspicion — reasonable grounds to suspect — is generally the threshold, not proof. You are not the investigator; you are the reporter. The duty typically rests personally on the individual who formed the suspicion, so telling your clinic owner is generally not a substitute for reporting yourself. A mandatory report is an authorized disclosure: confidentiality does not exempt you from a statutory duty. Child protection reporting duties exist across Canada; duties in respect of adults and older adults vary considerably by province and setting.

REMEMBER

- *Nobody consents to a reduced standard of care because they were not charged. Free is a fee decision, not a professional one.*
- *The standard travels with the registration, not with the building.*
- *Know which reporting duties apply to you before you are standing in front of one — ask your instructor for the contact points in your jurisdiction.*

Module 24 · Community safety and external relations

The RMT in local emergency plans: know your actual role — you are a regulated health professional with a defined scope and usually current first-aid certification. That is a real contribution; it does not make you a paramedic, and role confusion in an emergency is dangerous. Work within training: check, call, care, hand over. Be integrated, not freelance — turning up unannounced at an incident is not support; being known to local agencies in advance, with an agreed role, is. The standards still apply: austere conditions change what is possible, not what is required.

Environmental responsibility: never pour concentrates down the drain — disinfectant entering the municipal system is a community exposure. General, biohazardous, sharps and chemical waste each have a lawful destination; sending contaminated waste into general refuse exposes waste workers. The greenest control is at the top of the hierarchy: substitution and not wasting product. Linen laundering at volume is the clinic's largest continuous environmental footprint — and it is governed by hygienic requirements you cannot compromise.

Partnerships: informal links (the physiotherapist who knows your name, the GP who has met you) and formal links (referral agreements, multidisciplinary teams, a defined role in a local plan). A referral to a person is more likely to be completed than a referral to an institution.

REMEMBER

- *The most useful person in an emergency is the one who knows exactly what they are and are not there to do.*
- *Integration is not granted to the profession. It is built, one working relationship at a time.*
- *Infection control comes first: a clinic cannot reduce its laundry or disinfectant use below what hygiene demands.*

8. The six through-lines that connect the whole course

If you understand these six ideas, most of the examination follows. Each one appears in every lecture, and most scenario questions are testing one of them.

Through-line	What it means and 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 point-of-care risk assessment, and treating every client and every fluid as potentially infectious. You cannot tell by looking, and the client may not know. 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. PPE is the last line, never the first. The same hierarchy 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, L3 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 in any complaint, inspection or insurance matter (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 day on placement (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. Continuous improvement is the standard, not an aspiration (L1 M1, L2 M12, L3 M17).

9. Key terms you must be able to define and apply

Lecture 1 and Lecture 2 terms:

Term	What it means
Absolute contraindication	A condition that rules out treatment entirely — refer. The answer is no, not 'gently'.
Aseptic technique	Cleaning, then disinfection, and (rarely in massage) sterilization — the sequence that breaks the chain of infection.
Biofilm	A community of microorganisms adhering to a surface under a protective matrix. Dramatically more resistant to disinfectants; must be physically removed.
Chain of infection	Infectious agent → reservoir → portal of exit → mode of transmission → portal of entry → susceptible host. Break one link and transmission stops.
Contact time (wet/dwell time)	The period a surface must stay visibly wet with a product for its label kill claim to be achieved.
DIN (Drug Identification Number)	Confirms a disinfectant is authorized in Canada and kills the microbes claimed on its label.
Fomite	An inanimate object that carries infection between people — linens, face cradles, clipboards, pens, door handles, payment terminals.
Hazard	Anything with the potential to cause harm. A fact.

Term	What it means
Hierarchy of controls	Elimination → substitution → engineering → administrative → PPE. Most to least effective.
Internal Responsibility System	Everyone in the workplace holds a share of safety according to their authority and ability. Accountability rises with authority.
Local contraindication	Avoid a specific area but treat elsewhere. The area is excluded; the client is not.
PCRA (point-of-care risk assessment)	Three questions before every interaction: what is the task, what is my exposure risk, what controls does that require?
Relative / conditional contraindication	Treat with modification and, where needed, physician clearance.
Reservoir	Where an organism lives and multiplies — the client, the therapist, the table, a lotion pump, a damp towel.
Resident flora	Organisms in the deeper skin layers; hard to remove; not the target of routine hand hygiene.
Risk	Likelihood × severity. A judgment about a hazard's exposure and consequence.
Routine / standard practices	Treating all blood, body fluids, secretions, excretions and non-intact skin as infectious, for every client, every time.
Spaulding classification	Non-critical (intact skin — clean + low-level disinfection); semi-critical (non-intact skin/mucous membranes — high-level disinfection); critical (sterile tissue — sterilization).
Supplier label	Manufacturer's label on the original container — six elements.
Transient flora	Organisms acquired from the environment and other people; sit loosely on the skin; cause most cross-contamination; easily removed by hand hygiene.
WHMIS 2015	Canada's hazard communication system, aligned with GHS. Labels + SDS + training.
Workplace label	Required on any decanted container, or where the supplier label is lost or illegible — three elements.

Lecture 3 and Lecture 4 terms:

Term	What it means
5 Whys	Asking why repeatedly to trace an incident past its immediate cause to the underlying system gap.
Burnout	Exhaustion, cynicism, dread before work and a reduced sense of accomplishment. An occupational hazard, not a character flaw.
Check – Call – Care – Hand over	The universal first-aid response sequence.
Circle of care	Providers involved in a client's care who may share relevant information for that purpose, with the client's knowledge and consent.
Cultural safety	Judged by the person receiving care, not the practitioner providing it. A stance, not a body of trivia.
Exclusion criteria	When to defer treatment — defined in advance, applied consistently, communicated at booking.
Mandatory report	A statutory disclosure that client confidentiality does not override. Suspicion, not proof, is generally the threshold.

Term	What it means
Near miss	An event where no one was harmed. Reported and investigated — it is the cheapest lesson a clinic will get.
Repetitive strain injury	Cumulative injury from sustained force, repetition, awkward posture and few breaks. Early signs: aching, tingling, weakness or numbness lingering after work.
Safety culture	A workplace where hazards and near misses are raised without fear of blame, and concerns are acted on.
Social determinants of health	Income, housing, employment, education, food security, social support, discrimination and access to services — conditions that shape who is injured and who recovers.
Trauma-informed care	Asking what has happened to this person rather than what is wrong with them. Applied universally, like routine practices. Compliance is not consent.
Warm referral	A referral with a name, a number and a first step — not an instruction to 'see someone about that'.

10. Self-check — test yourself before the examination

These are the knowledge-check questions from the end of each lecture. They are not examination questions and will not be repeated — but if you cannot answer them from memory, you are not ready.

Question	Where to find it
What is the difference between a hazard and a risk?	L1 · Module 5
Name the three fundamental worker rights, and outline the refusal process.	L1 · Module 2
Order the hierarchy of controls from most to least effective.	L1 · Module 5
When must a workplace label be applied, and what three elements must it carry?	L1 · Module 3
Which SDS sections are the everyday ones for an RMT, and what does each answer?	L1 · Module 3
Name the six links in the chain of infection and a control that breaks each.	L1 · Module 6 · L2 · Module 7
Why must cleaning precede disinfection, and what is contact time?	L1 · Module 6 · L2 · Module 9
What are the four moments for hand hygiene?	L2 · Module 8
In what order is PPE removed, and why?	L2 · Module 8
Which Spaulding category covers a massage table?	L2 · Module 9
Name the three categories of contraindication, with an example of each.	L2 · Module 11
Name the five steps of an exposure response.	L2 · Module 10
Name the four occupational hazard categories for an RMT.	L3 · Module 13
What is the master variable in table set-up, and why?	L3 · Module 13
Name three early warning signs of repetitive strain injury.	L3 · Module 13
What are the four steps of the first-aid response sequence?	L3 · Module 15
Name the five steps of an incident response.	L3 · Module 16
What does the '5 Whys' approach look for, and why?	L3 · Module 16
Name four parties an incident may need reporting to.	L3 · Module 16

Question	Where to find it
What must you do before sharing a client's information with their physician?	L4 · Module 20
What makes a referral safe rather than an instruction?	L4 · Module 20
Who decides whether an encounter was culturally safe?	L4 · Module 22
What is the threshold for a mandatory report, and who must make it?	L4 · Module 23

11. How to prepare — a suggested plan

1. Start with the six through-lines in section 8. If you can explain each one and name two modules where it appears, you have the spine of the course.
2. Then work outward lecture by lecture using sections 4 to 7 as a checklist. Do not start with Lecture 3 and 4 simply because they are freshest — Sections A and B are 27 of the 50 marks.
3. Do not assume Lectures 1 and 2 are 'done' because Quiz 1 covered them. They are 54% of this paper, and the questions are new scenarios, not the quiz repeated.
4. Learn the lists that carry the reasoning: the chain of infection, the hierarchy of controls, the four moments, the three contraindication categories, the three label elements, the five-step risk assessment, the five-step exposure response, the five-step incident response, Check–Call–Care–Hand over, the doffing order, and the four reporting destinations.
5. For every list, have a clinic example ready. Most items are scenarios, and a list you can recite but cannot apply will not earn the mark.
6. Drill the distinctions the course returns to repeatedly: CMTCA vs the College; hazard vs risk; cleaning vs disinfection vs sterilization; resident vs transient flora; supplier vs workplace label; absolute vs local vs relative contraindication; soap and water vs alcohol-based rub; scope vs competence; education vs treatment; and cultural awareness vs cultural safety.
7. Practise the reasoning out loud with a classmate: one describes a clinic situation, the other names the hazard, the control, the standard and the documentation. This is exactly the reasoning the examination tests.
8. Use the self-check questions in section 10 as a closed-book test two evenings before, then spend your remaining time only on what you missed.
9. Remember the day's shape: the assignment is due on Day 3 and the examination is written the same day. Do not leave the assignment to the night before — you will spend the time you needed for revision.

12. How to answer multiple-choice questions in this course

- Read the stem twice before looking at the options. Note qualifiers — FIRST, MOST effective, BEST describes, NOT — because they decide the answer.
- Answer from the standard as taught in this course and in the College's Standards of Practice, not from what you have seen done on placement. A common clinic practice can still be the wrong answer.
- Predict the answer before you read the options, then find the option closest to your prediction. This resists plausible distractors.

- Several options may be partially true. Choose the one that is most correct and most complete — the one a regulator would accept.
- Distractors are built from real errors: reversing two terms, naming the right idea at the wrong step, applying a rule to the wrong category, or offering a shortcut that a busy clinic would take.
- Options containing 'only if harm occurred', 'provided the client agrees', 'if you are running behind', or 'unless you are busy' are almost always wrong. Safety obligations do not have convenience exceptions.
- Watch for the compliance trap: an option that sounds efficient or client-pleasing but skips a step (wiping before contact time elapses, reusing a cover that looks clean, treating a sensitive area because the client booked 'full body').
- There is no penalty for a wrong answer. Never leave a blank — eliminate what you can and choose.
- Mark difficult items, move on, and return. Do not spend five minutes on one mark.
- Change an answer only if you have a reason. A vague second-guess is usually worse than your first reading.

Timing: 90 minutes for 50 questions is about 1 minute 45 seconds per item. A workable plan is 30 minutes for Sections A and B, 30 minutes for Sections C and D, and 20 minutes to revisit the items you marked — leaving a margin. If you are past question 25 at the 45-minute mark, you are on pace.

13. Examination-day rules

- Bring photo identification and arrive early. Bags, coats and all electronic devices go to the front of the room — devices powered off, not silenced.
- Closed book: no notes, textbooks, slide handouts, annotated diagrams, or written material on your person, clothing or skin. This handout may not be at your desk.
- No phone, smart watch, earbud, fitness tracker or any device capable of receiving or storing information at your desk.
- Print your name and student number on the paper before you begin. An unnamed paper cannot be marked.
- Do not communicate with another student in any form during the assessment.
- Raise your hand if you think a question has a typographical error. Invigilators cannot interpret questions, confirm answers or tell you whether you are on the right track.
- Washroom breaks are supervised and recorded, one student at a time.
- Do not remove the paper, the answer sheet or any part of either from the room, and do not photograph or transcribe any item.
- Stop writing when time is called and remain seated until your paper has been collected.
- If you require an accommodation, arrange it in advance through the College's student accommodations process. An accommodation adjusts the conditions of an assessment; it never adjusts the standard.

14. Academic integrity

Academic integrity is not paperwork in a health-profession program. A mark obtained dishonestly on a health and safety assessment says you are competent in practices that protect people who cannot check them for themselves —

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. This is the same claim you will make every working day as a registrant, in a chart entry, an incident report and a service log. A student who fabricates an exam answer and a therapist who back-dates a disinfection log are doing the same thing: asserting that something was done which was not. This course teaches that if it isn't written, it didn't happen. Its corollary is that what is written must be true.

BY SUBMITTING YOUR PAPER, YOU DECLARE

That the work is entirely your own, that you have neither given nor received unauthorized assistance, and that you have complied with the conditions of the examination as stated on the paper.

WHAT COUNTS AS A VIOLATION

- Copying from another student's paper, letting another student copy from yours, or communicating during the assessment.
- Unauthorized material at your desk — notes, textbooks, handouts, annotated diagrams, or writing on your person, clothing or skin.
- Any electronic device at your desk, whether or not you used it.
- Obtaining, distributing or reproducing assessment content — photographing a paper, transcribing items afterwards, or passing items to another cohort or a future class.
- Impersonation — writing in place of another student, or arranging for someone to write in your place.
- Removing a paper or answer sheet, or any part of one, from the room.
- Writing after time is called, or altering a response after the paper has been collected.
- Falsifying a claim for accommodation, deferral or medical consideration.
- Sharing examination content with a student in another cohort or a future class. This matters particularly for a cumulative final, whose items are reused across deliveries — passing them on is not helping a classmate, it is devaluing the credential you are working for.

WHAT HAPPENS IF A VIOLATION IS SUSPECTED

1. The invigilator records what was observed, when, and by whom, and secures any material involved. You are normally permitted to finish the assessment.
2. The observation is reported in writing to the instructor and program administration the same day.
3. You are told the allegation and the specific observation it rests on, and you are given a genuine opportunity to respond before any finding is made.
4. A finding is made on the balance of probabilities, on the recorded evidence, by the person or panel named in the student manual — not by the invigilator alone.
5. The finding, the evidence, your response and the outcome are documented in your student file.
6. You may appeal the finding through the process in the student manual, within the timeframe stated there.

POSSIBLE OUTCOMES

Outcome	Typical circumstances
Documented warning and re-education	A first, minor, non-deliberate breach — for example a phone left in a coat pocket at your desk with no evidence of access.
Mark of zero on the examination	A substantiated breach affecting the integrity of your paper — unauthorized material at your desk, or communicating with another student.

Outcome	Typical circumstances
Failure of the course	A serious or repeated breach — impersonation, distributing examination content, or a second substantiated finding.
Suspension or dismissal from the program	The most serious breaches, and repeated findings after a prior sanction.
Referral for professional-suitability review	Where the conduct raises a question about your suitability for a regulated health profession, separately from the academic sanction.

Outcomes are proportionate to the seriousness of the conduct, your history, and how deliberate it was. Be clear-eyed about the arithmetic: a mark of zero on this examination removes 30% of your available final grade, capping your aggregate at 70% — reachable only with a perfect score on everything else, so in practice the course becomes unrecoverable in this delivery.

Note on this handout: it is a study aid 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. Confirm the examinable scope of Lecture 4 with your instructor. Bring any discrepancy you notice to your instructor — 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.