RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

REGISTERED MASSAGE THERAPY PROGRAM · DIPLOMA

Health & Safety

Lecture 2 — Infection Prevention & Control · Protecting Your Clients · Public Health

COURSE CODE	DURATION	INSTITUTION	LECTURE
RU RMT 12	20 hours · Day 1 of 3	Ruhani College	02 · 7 hours

Aligned with CMTCA accreditation standards and the FOMTRAC inter-jurisdictional entry-to-practice competencies for Safety & Risk Management.

Lecture 2 roadmap — IPAC & Client Safety

07	**The chain of infection & routine practices**	How infections spread — and treating every client as a potential source.
08	**Hand hygiene & personal protective equipment**	The four moments, correct technique, gloves, masks and eye protection.
09	**Cleaning, disinfection & linen handling**	Spaulding levels, contact times and managing clean versus soiled laundry.
10	**Communicable disease, exposures & waste**	Therapist illness, blood-borne pathogens and safe waste disposal.
11	**Client safety — consent, draping & screening**	Contraindications, safe positioning and protecting vulnerable clients.
12	**Public health & the RMT**	CMTCA, FOMTRAC, outbreak management, exclusion criteria and safety culture.

What Lecture 2 requires of you

Lecture objectives

- Understand the role of the CMTCA and the inter-jurisdictional standards in public safety.
- Identify the key public health responsibilities of a Registered Massage Therapist.
- Apply infection prevention and control (IPAC) protocols in the treatment room.
- Discuss risk management and the duty of care in a clinical setting.
- Explain the chain of infection and select the practice that breaks each link.
- Perform hand hygiene at the four moments and select PPE by point-of-care risk assessment.
- Obtain and maintain informed consent, drape correctly, and screen for contraindications.

Competency alignment

PC 1.2	Professional conduct.
PC 1.3	The therapeutic relationship.
PC 3.1	Maintain a safe and hygienic environment.
PC 3.1.2	Apply standard precautions and routine practices.
Standard 3	Hand hygiene and infection control.
Standard 5	Risk identification and management.

Verify all competency and standard numbering against the current FOMTRAC and College documents before student delivery.

How infections spread — the chain of infection

Infection requires six links. Routine practices and IPAC work by breaking even one link in this chain.

1	**Infectious agent**	*Bacteria, virus, fungus*	The pathogen capable of causing disease.
2	**Reservoir**	*People, surfaces, linens*	Where it lives and multiplies between hosts.
3	**Portal of exit**	*Skin, fluids, droplets*	How it leaves the reservoir.
4	**Transmission**	*Hands, contact, air*	How it travels — direct or indirect.
5	**Portal of entry**	*Broken skin, mucosa*	How it gets into the next person.
6	**Susceptible host**	*The next person*	Someone able to be infected.

Break any single link — through hand hygiene, cleaning, PPE or screening — and the infection cannot pass to the next person.

Breaking the chain — which practice targets which link

Infectious agent	Cleaning and disinfection with a product proven against the organism; hospital-grade disinfectant with a DIN.
Reservoir	Fresh linens for every client; disinfected table, bolsters and face cradle; no biofilm in oil bottles or pumps.
Portal of exit	Cover your own wounds with a waterproof dressing; respiratory etiquette; do not treat over an open lesion.
Transmission	Hand hygiene at the four moments — the single highest-yield control; 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; use PPE where splash is possible.
Susceptible host	Screen and re-screen; defer treatment where indicated; extra care for pregnant, older, immunocompromised clients.

You do not have to defeat the pathogen. You only have to be better than one link.

Routine practices — assume, don't guess

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. Standard precautions are applied to all clients, regardless of perceived risk.

Point-of-care risk assessment

Before each interaction, ask: what is the task, and what is my risk of exposure to skin, fluids or contaminated surfaces?

Hand hygiene at the right moments

The single most effective measure to prevent transmission in any health-care setting.

Appropriate PPE for the risk

Select gloves, mask or eye protection based on the assessment — not by habit.

Clean environment & equipment

Disinfect surfaces, tables and shared tools between every client.

Routine practices replace the old idea of protecting only against 'known' cases. The assumption is universal.

The point-of-care risk assessment — three questions

A point-of-care risk assessment (PCRA) is performed before every client interaction. It takes seconds and it drives every other choice you make.

1	**What is the task?**	What will I actually do — full-body Swedish work on intact skin, work near a healing scar, treatment of a client with a productive cough, handling soiled linen after the appointment?
2	**What is my risk of exposure?**	Am I likely to contact non-intact skin, blood or body fluids, mucous membranes, or a contaminated surface? Is a splash or a droplet exposure plausible?
3	**What controls does that require?**	Hand hygiene always. Then, proportionate to the assessed risk: gloves, a mask, eye protection, a modified technique, or deferral of the treatment altogether.

The PCRA is a habit of thought, not a form. It is what makes PPE a decision rather than a reflex.

The four moments for hand hygiene

1

BEFORE client contact

Protect the client from germs on your hands.

2

BEFORE a clean / aseptic task

E.g. applying a dressing to broken skin.

3

AFTER body-fluid exposure risk

Any contact with fluids, wounds or mucous membranes.

4

AFTER client & surroundings

After the treatment and after touching the client's environment.

Hand hygiene is the number one way to break the chain of infection. It protects clients from you, and you from clients. It is named in Standard 3 of the national standards as the single most effective way to prevent the spread of infection, and it is the practice most often skipped when a clinic runs late.

These map to the 'Your 4 Moments for Hand Hygiene' model used across Canadian health care.

The four moments across one appointment

Mapped onto a single 60-minute treatment, the four moments recur far more often than students expect.

Greeting & health history	Moment 1 — before client contact. Hand hygiene after handling the clipboard, pen or payment terminal and before you touch the client.
Client undresses & you leave the room	Hand hygiene on re-entering the room, before beginning treatment. Moment 1 again.
During treatment — you adjust a bolster, then touch the face cradle	Moment 4 — after contact with the client's surroundings. Re-perform hand hygiene before returning to skin contact.
Contact with broken skin, a weeping lesion or any fluid	Moment 3 — after body-fluid exposure risk. Hand hygiene immediately, and before touching anything else.
Treatment ends; you strip the table and handle soiled linen	Moment 4 — after the client and their environment. Hand hygiene after handling soiled linen even if gloves were worn.

If you performed hand hygiene twice in an appointment, you missed moments.

Doing it right — soap vs. alcohol-based rub

Soap & water — when?

- Hands visibly soiled with dirt, oil or body fluids
- After using the washroom
- Before eating
- When exposed to certain spore-forming germs
- Lather 15–20 seconds, covering all surfaces
- Dry thoroughly with a clean paper towel

Alcohol-based rub — when?

- Hands not visibly soiled — most situations in practice
- Faster and gentler on skin than repeated washing
- Use enough product to cover all surfaces
- Rub until completely dry — roughly 20–30 seconds
- Keep nails short; remove rings and wrist jewellery
- Cover cuts with a waterproof dressing

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. This is a practice rule, not a dress preference, and it applies from the moment you enter the treatment area.

Technique — the parts everyone misses

Duration and coverage are what make hand hygiene work. Most failures are not refusals — they are rushed, partial applications.

1	**Enough product**	Too little product cannot cover every surface and will dry before the required time has elapsed. For rub, use enough to keep hands wet for the full duration.
2	**All surfaces**	Palms, backs of hands, between every finger, thumbs, fingertips and nail beds, and wrists. Fingertips and thumbs are the most commonly missed and the most used in massage.
3	**Full duration**	Lather 15–20 seconds with soap; rub until completely dry, roughly 20–30 seconds. Do not wave hands dry or wipe product off on a towel or your uniform.
4	**Dry properly**	Wet hands transfer organisms far more readily than dry hands. Dry fully with a clean single-use paper towel and use it to turn off a manual tap.
5	**Protect your skin**	Cracked, over-washed skin holds more organisms and is a portal of entry. Use lotion compatible with your products, and report dermatitis rather than working through it.

Skin integrity is part of hand-hygiene competence — protecting your hands is a professional obligation, not vanity.

Personal protective equipment — match it to the risk

Gloves

When contact with broken skin, body fluids or contaminated items is likely. Perform hand hygiene before and after — gloves are not a substitute for hand hygiene, and they are not a licence to skip it.

Mask

When respiratory illness is present, when droplets are possible, or when directed by public-health guidance or a current directive.

Eye protection

If splashes or sprays to the face are possible. Less common in massage therapy, but assess rather than assume — hydrotherapy and wound proximity are examples.

Gown / apron

When clothing may be contaminated. Remove and launder or discard appropriately; do not carry a contaminated gown between rooms.

Sequence matters: put PPE on before contact and remove it carefully afterward — gloves first — then perform hand hygiene. Single-use PPE is never reused, never washed, and never pocketed for later.

Putting it on, taking it off — sequence matters

Donning — before contact

- Perform hand hygiene first
- Gown or apron — fasten at the back
- Mask — secure, covering nose and mouth, mould to the nose
- Eye protection — position over the eyes
- Gloves last — over the gown cuff
- Do not adjust PPE once you begin the task

Doffing — after contact

- Gloves first — they are the most contaminated item
- Perform hand hygiene
- Gown or apron — roll away from the body, contaminated side in
- Eye protection — handle by the arms or strap, not the front
- Mask last — handle by the ties or loops, never the front
- Perform hand hygiene again

The principle behind the order: the outside front of every item is contaminated. You remove the dirtiest item first, and you touch only the parts that stayed clean — ties, loops, straps and the inside. Self-contamination during removal is the most common PPE failure in every health-care setting, and it happens because people rush the last ten seconds of a task they have already finished.

Clean, disinfect, sterilize — the right level

The Spaulding classification matches the level of reprocessing to how an item contacts the body. Most massage items are non-critical.

CATEGORY	BODY CONTACT	REQUIRED LEVEL	MASSAGE EXAMPLES
Non-critical	Intact skin only	Clean + low-level disinfection	Table, bolsters, stones, your hands
Semi-critical	Non-intact skin / mucous membranes	High-level disinfection	Rarely applicable in massage therapy
Critical	Enters sterile tissue / bloodstream	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. In practice, massage therapists focus on thorough cleaning and low-level disinfection of surfaces and equipment that touch intact skin.

Applying Spaulding to the items you actually touch

Treatment table, bolsters, face cradle frame	Non-critical — clean, then low-level disinfect between every client. Non-porous and intact, or it cannot be disinfected at all.
Hot stones and hydrotherapy equipment	Non-critical, but they sit in warm water — a reservoir. Clean and disinfect per manufacturer directions; never leave standing water.
Oil and lotion containers and pumps	Non-critical, and the classic biofilm site. Never top up a bottle; wash and dry it fully or discard it. Never dip fingers into a communal jar.
Linens, face-cradle covers, bolster covers	Single-client use. Not disinfected — laundered. A cover that touched one client is soiled even if it looks clean.
High-touch non-clinical surfaces	Door handles, light switches, payment terminal, pens, clipboards, phone. Non-critical, and routinely forgotten between clients.
Anything penetrating the skin	Critical — outside massage therapy scope unless a separate authorized activity applies, and then only with validated sterilization or single use.

If it touched a client and it cannot be laundered, it must be cleaned and disinfected before the next one.

Disinfecting the treatment room between clients

1	**Clean first**	Remove visible soil and oil. Disinfectants do not work on dirty surfaces — organic matter physically shields the organisms.
2	**Apply disinfectant**	Use a product effective against the relevant pathogens, carrying a DIN; cover the whole surface, not just the visible middle.
3	**Respect contact time**	Keep the surface visibly wet for the full 'wet time' stated on the label. This is the step that is skipped.
4	**Target high-touch points**	Table, face cradle, bolsters, light switches, door handles, oil bottles — and the stool, the pen and the payment terminal.
5	**Let dry & re-set**	Allow to air-dry as directed; place fresh linens; perform hand hygiene before you touch anything clean.

Contact time is the most common failure point — wiping a surface dry too soon means it was never disinfected.

Contact time — the step that decides everything

Contact time — also called wet time or 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 not a suggestion, it is the condition under which the product was tested and licensed.

Read it, don't assume it

Contact times vary by product and by organism — from under a minute to ten minutes. Two bottles that look identical may differ. The time is on the label and in SDS section 7.

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, this means re-application — not a harder wipe.

Time it honestly

Between clients, the pressure to reset the room in ninety seconds is the single biggest driver of IPAC failure in private practice. Build the contact time into the schedule, not around it.

Clean first, always

Contact time on a soiled surface is wasted time. Oil and lotion shield organisms from the disinfectant regardless of how long it dwells.

A disinfected room takes as long as the label says. If the schedule doesn't allow it, the schedule is the hazard.

Linen handling — clean in, soiled out

1 **Fresh linens per client**

Use clean sheets, face-cradle covers and bolster covers for every single client — no exceptions, no 'they were only on the table for ten minutes', no reuse for a family member.

2 **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.

3 **Wash separately & hot**

Launder contaminated linens separately, on the hottest setting the fabric allows, and dry completely. Damp linen is a reservoir; incomplete drying undoes the wash.

Never shake soiled linen. It is the fastest way to turn a clean room back into a contaminated one.

Linen handling — separation and discipline

4	**Separate clean & soiled**	Store and transport clean and soiled linens apart to prevent cross-contamination. A clean stack carried under the same arm as a soiled bundle is now a soiled stack.
5	**Hygiene after handling**	Perform hand hygiene after touching any soiled linen, even if gloves were worn — hands contaminate during glove removal.
6	**Never re-use a cover**	A cover that touched one client is soiled — even if it looks clean, even if the client was 'clean', even if you are running behind.

'It looks clean' is not a standard. Single-client use is the standard.

When illness is in the room — if you are unwell

Working while infectious exposes every client you see that day, and a massage therapist cannot distance from the client. Your judgment here is a public-health act.

- Defer or refuse treatment if you have a communicable disease that no barrier can contain — this is expressly permitted and expected by the standards.
- Stay home with fever, vomiting or diarrhoea. Do not treat and do not attend the clinic.
- Cover cuts and abrasions with waterproof dressings before you arrive, and glove where the dressing cannot be secured.
- Keep immunizations up to date. Hepatitis B vaccination is strongly recommended for health-care providers, including massage therapists.
- Follow public-health directives currently in force — they change, and the obligation is to the version in force today.
- Notify the clinic promptly so appointments can be rescheduled rather than quietly handed to a colleague at the last minute.

Declining care to protect others is a professional duty, not a failure — and it is never grounds for reprisal.

When illness is in the room — if the client is unwell

- Screen for symptoms before the appointment — at booking, at confirmation and again on arrival. Screening after the client is on the table is too late.
- Reschedule active, transmissible infections. A client with an acute respiratory illness, active gastrointestinal illness or an infectious skin condition is deferred, not draped around.
- Apply extra precautions where appropriate — a mask, altered scheduling, treatment at the end of the day, increased ventilation, or a modified technique.
- Disinfect thoroughly after the visit, allowing full contact time, and consider the room's turnover before the next client.
- Notify and document if others may have been exposed, and follow the clinic's and public health's reporting procedure.
- Identify and report communicable diseases where reporting is required — the RMT is part of the primary health-care system's early-warning network.

Rescheduling a sick client protects the six clients who follow them into that room.

Blood-borne pathogens in a massage practice

Blood-borne pathogens — for example hepatitis B, hepatitis C and 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, and the therapist's hands are the point of contact.

Why it matters here

The therapist works with bare hands, under friction and warmth, on skin, for an hour. 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.

Hepatitis B vaccination

Strongly recommended for health-care providers, including massage therapists. It is the one blood-borne pathogen in this group with a vaccine — take it.

Prevention is routine practice

Intact skin on both parties, waterproof dressings, gloves where indicated by the point-of-care risk assessment, and no treatment over non-intact skin.

Assume, don't ask

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.

Exposure response — five steps, rehearsed

1	**Stop & cover**	Stop treatment immediately. Cover any wound on you or the client. Do not continue the appointment and 'deal with it after'.
2	**Wash the area**	Wash the exposed site with soap and water immediately. Flush eyes with water if splashed. Do not scrub, squeeze or apply bleach to the wound.
3	**Clean & disinfect**	Decontaminate the surfaces involved and dispose of contaminated items safely as regulated waste.
4	**Report & seek care**	Report the exposure to your supervisor or clinic. Seek medical assessment promptly — timing matters for post-exposure follow-up.
5	**Document**	Complete an incident report with the facts and the actions taken: what, when, who was involved and what was done.

Keep it procedural: stop, wash, clean, report, document. Seek medical assessment promptly — do not wait until the end of the day.

Handling and disposing of waste safely

General waste

Everyday non-contaminated waste goes in lined, covered bins emptied regularly. Covered matters: an open bin of used tissue beside a treatment table is a reservoir.

Biohazardous waste

Items soaked with blood or body fluids are handled as regulated waste in designated containers — never in the general bin, never in the linen hamper.

Sharps (if ever present)

Any sharp goes directly into a puncture-proof sharps container — never loose in the trash, never recapped by hand. Relevant if acupuncture is within scope as a separate authorized activity.

Chemical disposal

Follow the Safety Data Sheet and local rules; never pour concentrated chemicals down the drain. SDS section 13 covers disposal.

Most massage clinics generate mainly general waste and soiled linen. Know the escalation path for the rare biohazard or sharp before it appears.

Informed consent — safety begins with permission

Consent is a continuous conversation, not a one-time signature. It protects the client's autonomy and is central to safe, ethical care — and it is a competency of professional conduct and the therapeutic relationship, not merely paperwork.

Explain & discuss

Describe the proposed treatment, the areas to be worked, the expected sensations and any risks — including public-health risks where relevant, such as during a respiratory virus outbreak.

Obtain voluntary consent

The client agrees freely, with the capacity to understand what is proposed. For sensitive areas, obtain specific consent for that area, at that visit.

Right to withdraw

A client may refuse, modify or stop treatment at any time, regardless of prior consent, and without needing to justify the decision.

Check in during treatment about pressure, comfort and warmth. Silence is not consent — keep the dialogue open.

Consent in practice — what it sounds like

At booking and intake	The client knows what the treatment involves before they are undressed on a table. Consent obtained from a person already draped and prone is compromised by the situation itself.
Before treatment begins	Confirm the plan, the areas, the pressure and the draping. Ask explicitly for any sensitive area, name it plainly, and record the answer.
During treatment	Check pressure, comfort and warmth. Watch for withdrawal, guarding, breath-holding and silence — the client may not feel able to speak up.
When the plan changes	New area, new technique, new pressure — new consent. What was agreed for the shoulder is not consent for the ribcage.
Capacity and voluntariness	Consent must be free of pressure and given by someone with the capacity to understand. For minors and dependent clients, involve the guardian appropriately.
Documentation	Record what was explained, what was agreed and any concern raised. Consent that is not documented is difficult to demonstrate later.

Consent is the difference between treatment and assault. There is no version of this that is administrative.

Draping protects dignity and safety

- Keep the client covered at all times; expose only the area being treated, and only for as long as it is being treated.
- Re-drape an area before moving to the next. The drape is repositioned by you, deliberately — never allowed to slip.
- Allow the client to undress and dress in private, with the door secured and adequate time. Knock and wait before re-entering.
- Confirm comfort with the draping at the start, and check again if the client is repositioned or appears to adjust it themselves.
- Use secure draping for turning and repositioning — the drape is held and controlled through the turn, not left to the client to manage.
- Ensure the drape is adequate for the treatment: enough coverage, enough fabric, and warm enough that the client is not obliged to trade dignity for comfort.

Draping is both a dignity measure and an abuse-prevention measure. It protects the client, and it protects you.

Boundaries & sensitive areas

- Sensitive areas include the chest and breast, the gluteal region, the groin and the abdomen. Treat the list as a floor, not a ceiling — if a client would reasonably regard an area as sensitive, it is.
- Never treat a sensitive area without specific consent, obtained for that area, at that visit, and documented.
- Maintain professional boundaries at all times — in language, in touch, in conversation, and in the therapeutic relationship outside the room.
- Recognize and stop any inappropriate situation immediately, whether it originates with the client or with you. Ending a treatment is always available to you.
- Document consent and any concerns raised, including anything you declined to do and why.
- Understand that the client's vulnerability — undressed, prone, unable to see you — never diminishes with familiarity. A long-standing client is not a lesser consent obligation.

Specific consent for sensitive areas is mandatory. There is no implied consent for the gluteal region because the client booked a 'full body' massage.

Screening & contraindications — when not to treat

A thorough health history protects the client from harm. Some conditions change, limit, or rule out treatment entirely. Health-history screening for contraindications and infectious risks is mandatory, not optional.

Absolute

Do not treat — for example acute systemic infection or certain acute conditions. Refer to a physician. The answer is no, not 'gently'.

Local

Avoid a specific area — for example 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 — for example some cardiovascular conditions. The plan changes; sometimes the answer waits for a clearance letter.

Re-screen at every visit

Health status changes between appointments. Re-screening catches 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. Standardized screening questionnaires help identify at-risk clients consistently rather than relying on memory.

When in doubt, don't. Treating beyond your competence — or against a contraindication — is unsafe and unethical. Refer.

Safe positioning, transfers & fall prevention (1 of 2)

1 **Support & bolster**

Use bolsters and pillows to support joints and maintain safe, comfortable positioning. Unsupported joints held for an hour are an injury, not a relaxation.

2 **Assist on and off**

Lower the table; offer a step stool and a steadying hand getting on and off. Ask before you touch — assistance is contact and contact is consented.

3 **Plan transfers**

For clients with mobility limits, plan the transfer before it starts and ask before assisting. Know what the client can do themselves, and what they cannot.

Falls getting on and off the table are the most common client incident in massage therapy.

Safe positioning, transfers & fall prevention (2 of 2)

4	**Turn safely**	Guide repositioning and turning; never let a client pivot unaided on a narrow table. Control the drape through the turn and keep a hand available.
5	**Clear the floor**	Wipe oil spills at once; keep cords, bags, bolsters and the client's own belongings out of walkways. The client walks this floor barefoot and half-asleep.
6	**Rise slowly**	Let clients sit up gradually to avoid dizziness and fainting after lying down. Stay in the room; do not leave a client to get up alone immediately after treatment.

The client is warm, relaxed, barefoot and possibly hypotensive. Treat the last two minutes of the appointment as the highest-risk two minutes.

Extra care for vulnerable clients

Pregnancy

Use safe positioning and bolstering; screen for complications; modify pressure and avoid certain areas. Positioning changes by trimester and by client.

Older adults

Fragile skin, thinner bones and balance issues — lighter pressure, careful transfers, and more time getting on and off the table.

Complex medical conditions

Cardiovascular disease, diabetes, blood thinners and cancer care need screening and often physician clearance. Blood thinners change what pressure means.

Minors & dependent clients

Consent, a guardian's involvement and heightened boundary awareness are essential. Know your clinic's policy on a guardian's presence in the room.

Vulnerable groups need modified technique and more careful screening. When uncertain, seek physician clearance — and document that you did.

Adverse events & incident reporting

Even with good practice, things happen — a faint, a fall, a reaction, a possible infection exposure. How you respond and how you record it are both part of safe care.

Respond

- Ensure the client's immediate safety
- Provide or summon first aid as needed
- Stay calm, reassure, and don't leave them alone
- Address the hazard so no one else is harmed

Record & report

- Document the facts: what, when, who, actions taken
- Notify the client and, if an exposure, those affected
- Report internally and follow clinic procedure
- Review to prevent a recurrence

Incident reports are not about blame — they protect the client, support learning, and document your professional response.

The regulatory landscape behind these practices

CMTCA — Canadian Massage Therapy Council for Accreditation

Ensures education programs meet national quality and safety standards. The IPAC content you are learning today exists in this form because an accredited program must demonstrate that its graduates can maintain a safe and hygienic environment.

FOMTRAC — Federation of Massage Therapy Regulatory Authorities of Canada

Oversees the Inter-Jurisdictional Practice Competencies and their performance indicators — the document that defines what a competent new RMT must be able to do on their first day.

The goal

Consistency in entry-to-practice skills across the regulated provinces — Ontario, British Columbia, New Brunswick, Newfoundland and Labrador, and Prince Edward Island. A client in one province should be able to expect the same standard of hygiene, consent and screening as a client in another, and an RMT should be able to move between them.

Public health & the RMT

Public health — definition

The organized effort to prevent disease, prolong life and promote health through society. It is a collective project, and every regulated health professional is part of the mechanism.

The RMT's role

Gatekeeper in the primary health-care system	Clients often see an RMT more frequently, and for longer, than any physician. You see skin, posture, swelling, moles and distress that nobody else sees — and you are positioned to notice and refer.
Identifying and reporting communicable diseases	Recognizing a transmissible condition, deferring treatment, and reporting where reporting is required. The RMT is part of the early-warning network, not a bystander to it.
Maintaining a sanitary environment to prevent community spread	Every practice in Modules 7 to 11 is a community measure. Your treatment room connects dozens of households each week.

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

Inter-jurisdictional standard: professional practice

Focus: Competency 1.2 (professional conduct) and Competency 1.3 (the therapeutic relationship). Public health obligations sit inside these competencies — they are not a separate rulebook.

Legal compliance

Adhering to federal, provincial and municipal health orders. Orders change and they bind you as they are today — not as they were when you were taught.

Informed consent

Clearly communicating risks related to public health — for example during a respiratory virus outbreak — so the client's agreement is genuinely informed.

Health history

Mandatory screening for contraindications and infectious risks, at intake and re-screened at every visit.

Environmental safety

Surface disinfection of high-touch points, linen management, and safe waste disposal. The standard names these explicitly; Modules 9 and 10 are how you meet it.

Verify competency numbering and the current health orders in force against the FOMTRAC and public-health sources before delivery.

Risk identification & management (Standard 5)

1	**Outbreak management**	Procedures for when a public health risk is identified by the Chief Medical Officer of Health — enhanced screening, masking, altered scheduling, temporary closure, or suspension of certain services. You follow the directive in force, and you follow it promptly.
2	**Screening tools**	Using standardized questionnaires to identify at-risk clients. A written tool applied to everyone is more reliable and more defensible than a therapist's memory and intuition, and it removes the discomfort of deciding who to ask.
3	**Exclusion criteria**	When to defer treatment for the safety of the public and the practitioner. Defined in advance, applied consistently, and communicated to clients at booking — so that the decision is a policy, not an argument at the front desk.

Duty of care: the client is owed a reasonable standard of care, and the public is owed a practitioner who knows when to stop.

Quality, safety culture & professional responsibility

Continuous improvement	RMTs must engage in ongoing professional development regarding health and safety. Your training expires; the obligation does not.
Evidence-informed practice	Using the latest public health data to inform clinical decisions — not habit, not what the clinic has always done, not what a supplier claims.
Safety culture	A clinic environment where safety incidents are reported and analyzed without blame. Blame produces silence, and silence produces repetition.

Conclusion & professional responsibility

Public health is not just about the individual; it is about the community. Adhering to inter-jurisdictional standards ensures labour mobility and public trust. Final thought: safety is a competency, not a checklist.

References

- CMTCA Accreditation Standards (2024/2026).
- FOMTRAC Inter-Jurisdictional Practice Competencies and Performance Indicators.
- Provincial Regulatory College Standards (e.g. CMTO, CMTBC).
- Public Health Agency of Canada (PHAC) Guidelines.

Key takeaways & knowledge check

Remember

- Break the chain of infection at any link
- Treat every client with routine practices
- Hand hygiene is the #1 protective measure
- Match PPE to the point-of-care risk
- Respect disinfectant contact time
- Never shake soiled linen; never reuse a cover
- Consent is ongoing; clients can withdraw anytime
- Screen, re-screen, and refer when unsure
- Safety is a competency, not a checklist

Check your understanding

1. Name the six links in the chain of infection.
2. What are the four moments for hand hygiene?
3. When do you use soap & water instead of a hand rub?
4. Why does disinfectant contact time matter?
5. Name the three categories of contraindication.
6. In what order is PPE removed, and why?
7. Which Spaulding category covers a massage table?
8. Name the five steps of an exposure response.

Up next

Day 3 — Protecting yourself: therapist body mechanics, psychosocial hazards, emergency response, incident investigation and building a culture of safety.