



RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

RUHANI COLLEGE OF MASSAGE THERAPY

Registered Massage Therapy Diploma Program

Standards of Practice, Consent and Professional Accountability

The professional, ethical and legal framework that governs every hydrotherapy treatment you will give in Ontario.

RU RMT 25 • Hydrotherapy • 70 Hours • 10 Days • Lecture 3 of 10

Aligned to CMTO Standards of Practice (2022), FOMTRAC inter-jurisdictional competencies and CMTCA accreditation requirements.

Compiled from RU RMT 25 Day 1 Lecture 4 (Standards of Practice & Informed Consent). Expanded against the CMTO Standards of Practice (2022), the Massage Therapy Act, 1991, the Health Care Consent Act, 1996 and PHIPA.

By the end of this lecture you will be able to:

- Describe the regulatory structure that governs massage therapy practice in Ontario.
- State the professional standards that apply to hydrotherapy specifically.
- Obtain valid, ongoing informed consent for a thermal treatment, meeting all six CMTO elements.
- Apply draping, privacy and dignity standards during hydrotherapy applications.
- Maintain sanitation and infection-control standards for tubs, basins, linens and equipment.
- Document treatment, response and home care to the professional standard required by CMTO and PHIPA.
- Recognise conduct that would constitute professional misconduct under O. Reg. 544/94.



How this lecture is organised

Part A — The framework

- Who regulates massage therapy in Ontario and why
- Scope of practice and the limits of competence
- The CMTO Standards of Practice set (2022)
- The Code of Ethics and duty of care
- Professional misconduct under O. Reg. 544/94

Part B — The obligations in practice

- Informed consent: elements, process and documentation
- Capacity, substitute decision-makers and the HCCA
- Draping, privacy and dignity
- Infection prevention and control for wet modalities
- Record keeping, PHIPA and the treatment record
- Safety incidents, disclosure and quality assurance



Who regulates massage therapy in Ontario

- The College of Massage Therapists of Ontario (CMTO) is the regulator established by the provincial government to regulate the practice of massage therapy and govern the conduct of Massage Therapists.
- CMTO's mandate is to protect the public interest — it is not a school, an association or an advocacy body.
- It sets the requirements for registration, so that only qualified individuals may use the protected titles 'Massage Therapist' and 'Registered Massage Therapist'.
- It maintains the public register ('Find an RMT') so the public can verify a practitioner's standing.
- It sets Standards of Practice that establish the minimum requirements and expectations for all RMTs in Ontario, regardless of role, job description or practice environment.
- It runs the quality assurance program (STRIVE) and the complaints, discipline and fitness-to-practise processes.
- The Registered Massage Therapists' Association of Ontario (RMTAO) is the professional association — a separate body with a different function.



Practising within scope and within competence

Scope of practice

- Defined by the Massage Therapy Act, 1991: assessment and treatment of soft tissue and joints to develop, maintain, rehabilitate or augment physical function, relieve pain and promote health.
- Hydrotherapy sits inside that scope as an adjunct that prepares tissue, manages pain and supports home care.
- Massage therapy is a regulated profession under the Regulated Health Professions Act, 1991; RMTs are not authorised to perform controlled acts beyond those permitted to the profession.

Competence

- Scope tells you what the profession may do; competence tells you what you may do.
- You may use a modality only where you have the training, knowledge and demonstrated skill to use it safely.
- CMTO rescinded its separate complementary-modalities policy: the questions now are whether the modality is within scope, whether you are competent, and whether informed consent can be obtained.
- Refer when a presentation falls outside your scope or your training.



The CMTO Standards of Practice (2022)

Each Standard states a Client Outcome, an RMT Outcome and a set of numbered Requirements. All were approved 9 February 2021.

Standards most engaged by hydrotherapy

- Safety and Risk Management
- Consent
- Infection Prevention and Control
- Record Keeping
- Draping and Physical Privacy
- Client-centred Care
- Communication

Also in the set

- Acupuncture
- Collaboration and Professional Relationships
- Collecting Personal Health Information from Patients
- Conflict of Interest
- Fees and Billing
- Prevention of Sexual Abuse
- Privacy and Confidentiality; Professional Boundaries
- Plus the Code of Ethics, Advertising, Cannabis and Social Media guidance



The requirements that govern a hydrotherapy setting

Client Outcome: the client receives care that is delivered as safely as possible. RMT Outcome: the RMT takes preventative and risk-management measures to provide safe care.

- The practice setting must be maintained in a safe and sanitary manner.
- It must be cleaned and disinfected regularly, including all equipment.
- It must be appropriately lit and arranged to allow sufficient physical and personal privacy and safety for each client.
- Maintenance of the practice setting must be documented in an equipment service record or log.
- RMTs must adhere to current health and safety government orders and directives, legislation and CMTO guidance — and where requirements differ, follow the most restrictive.
- Hazardous materials must be handled safely, including under WHMIS requirements.
- RMTs must recognise and manage situations that place clients, themselves, other RMTs and staff at risk.
- Safety incidents must be responded to effectively to minimise harm, documented, and disclosed to relevant authorities to prevent future adverse events.



What those requirements mean for wet modalities

Equipment and environment

- Tubs, basins and footbaths disinfected between every client
- Hydrocollator water level maintained above the packs; tank cleaned per manufacturer guidance
- Paraffin bath thermostat monitored with an independent thermometer
- Electrical units — cords, casings, switches — inspected before each use and removed from service if damaged
- Wet floors managed as a slip hazard; hot water sources kept out of client reach

Records and hazardous materials

- An equipment service log recording cleaning, temperature checks, maintenance and any unit taken out of service
- Safety data sheets for disinfectants, additives and cleaning agents held and accessible under WHMIS
- Additives stored, labelled and diluted per manufacturer directions
- A documented process for reporting and reviewing any burn, scald, fall or adverse reaction
- Staff training on the equipment in use, refreshed as appropriate for the setting



CONSENT

Assessment and treatment begin only after the client has given consent — and the client is always aware they can withdraw it.

That is the Client Outcome CMTO sets for the Consent Standard. The corresponding RMT Outcome is that the therapist obtains informed consent from clients, or their substitute decision-makers, prior to and throughout assessment and treatment. 'Throughout' is the word students most often miss, and thermal applications are exactly the case where it matters.



The six elements of the consent discussion

Requirement 1: prior to conducting an assessment, providing treatment, or modifying a treatment plan, the RMT must obtain the client's consent, and the discussion must cover all six.

- 1 The nature of the treatment.** Which modality, applied where, at what temperature, for how long, and what it will feel like.
- 2 The expected benefits.** What you are aiming to achieve and how it fits the treatment plan.
- 3 Risks and side effects.** Transient redness, discomfort during the cold phase, the possibility of a burn or a skin reaction to an additive.
- 4 Alternative courses of action.** A milder application, a different modality, or manual treatment with no thermal component.
- 5 Likely consequences of not having treatment.** What is likely to happen if the thermal component is omitted.
- 6 The right to ask questions and to stop.** Confirm the client may ask about anything and may have treatment stopped or modified at any time at their request.



Six further requirements you must be able to state

- If you lack sufficient information about the risks, benefits and contraindications of a modality or product — including topical products, lubricants and additives — consent cannot be obtained and it must not be used.
- Consent must relate to the treatment being proposed, be voluntary, and must not be obtained through misrepresentation or fraud.
- The client giving consent must be capable; if incapable, a substitute decision-maker may consent, and if no substitute decision-maker is available, the RMT must refuse to provide assessment or treatment.
- The RMT must monitor the client throughout assessment and treatment and, when appropriate, reverify consent.
- Written informed consent is required prior to every assessment or treatment of sensitive areas — the upper inner thighs, chest wall muscles and breasts; written consent is also required before assessing or treating the gluteal muscles, obtainable once per treatment plan with verbal confirmation each visit.
- Consent conversations must be documented in the client health record within 24 hours, and any written consent kept in that record.



Obtaining consent for a thermal treatment

- 1 **Describe the modality.** What you propose, where, how hot or cold, how long, and how it will feel through its course.
- 2 **State benefits and risks.** Likely effects, plus risks such as redness, burn or skin reaction — in plain language, not clinical shorthand.
- 3 **Offer alternatives.** Including a milder application and the option of no thermal work at all.
- 4 **Invite questions.** Confirm understanding; check the client can restate what will happen.
- 5 **Obtain agreement.** Record verbal consent, or written consent where required, before beginning.
- 6 **Re-confirm throughout.** Check comfort and willingness during the application, between contrast cycles, and at every change of plan.



Capacity and substitute decision-makers

Capacity under the HCCA

- A capable person understands the information relevant to the decision and appreciates the reasonably foreseeable consequences.
- Capacity is decision-specific and can change over time — a client may be capable for one decision and not another.
- Capacity is presumed unless there is reason to believe otherwise.
- Age alone does not determine capacity in Ontario; there is no fixed age of consent for treatment.

When a client is incapable

- A substitute decision-maker may consent on the client's behalf, in the hierarchy set out in the Health Care Consent Act, 1996.
- If a client is incapable and no substitute decision-maker is available, the RMT must refuse to provide assessment or treatment.
- Document the capacity concern, who consented, and their authority to do so.
- CMTO publishes a Guide to Capacity and Consent in Massage Therapy for detailed guidance.



Consent is a conversation, not a form

What good consent sounds like

- Plain language, no jargon: 'a hot pack, about as hot as a warm bath, for fifteen minutes' rather than 'thermotherapy'.
- Named risks, not vague reassurance: 'your skin will go pink; if it stings or goes blotchy, tell me and I will take it off'.
- A genuine alternative offered, not a formality.
- Space for the client to ask, and a check that they understood.
- An explicit invitation to stop the treatment at any point.

What undermines it

- Announcing rather than asking: 'I'm going to put a hot pack on you now.'
- Obtaining consent while the client is already prone and draped.
- Consent taken once at intake and never revisited.
- Using an intake form as a substitute for the discussion.
- Continuing after a client says 'that's quite hot' without re-checking.
- Consenting a client to a modality you cannot yourself explain.



Physical privacy during hydrotherapy

Draping requirements

- Drape so that only the area being assessed or treated is exposed.
- Provide a private space for the client to undress and dress.
- Explain before touching, repositioning or moving the drape.
- Comply with the Standard of Practice: Draping and Physical Privacy for the client's physical privacy and safety — this is also Requirement 10 of the Safety and Risk Management Standard.

Hydrotherapy-specific issues

- Wet modalities often require more exposure and more repositioning than dry manual work — plan the draping before you begin.
- Foot baths, salt glows and full-body applications need particular attention to modesty and warmth.
- Protect the client from chilling: a partially draped client in a cool room is both uncomfortable and thermally compromised.
- Where a client must move to a wet area, ensure the route is private, warm and non-slip.



Routine practices for wet and shared equipment

- Perform hand hygiene before and after every client contact and after handling used linens or water.
- Disinfect tubs, basins, footbaths and any immersion vessel between clients, using a product and contact time appropriate to the surface.
- Use clean linens and towels for every client and launder used items appropriately.
- Use single-use barriers where available — liners for paraffin, disposable probes for sensation testing.
- Discard used paraffin; never return it to the bath.
- Do not treat a client with an active skin infection at the site with shared equipment.
- Follow PIDAC and Public Health Ontario best practices for clinical office practice and environmental cleaning.
- Keep hydrocollator water above the packs and clean the tank on a documented schedule.



What the treatment record must show

The hydrotherapy entry

- Screening findings, including skin inspection and the sensation test result
- Clinical reasoning for choosing or withholding the thermal component
- Modality, measured temperature or setting, barrier or layering used, site and duration
- Skin checks performed and what was observed at each
- Client response, subjective and objective
- Any adverse reaction and the action taken
- Home-care guidance given, and the reassessment plan

Standards that govern the record

- CMTO Record Keeping — the content, retention and format of client health records
- CMTO Consent — consent conversations documented within 24 hours
- CMTO Collecting Personal Health Information from Patients — collect what is needed, in a client-centred way, without over-collecting
- PHIPA, 2004 — collection, use, disclosure, safeguarding and retention of personal health information
- Privacy and Confidentiality Standard — including confidentiality online



The Code of Ethics applied to hydrotherapy

- Act in the client's best interest and hold a duty of care throughout the treatment.
- Practise with integrity: do not overstate what a modality can achieve.
- Respect client autonomy — the right to refuse, to modify and to stop, at any point and without justification.
- Respect confidentiality of all health information, including what is discussed casually during a long application.
- Maintain professional boundaries; a long, quiet, warm application is exactly the context in which boundary drift begins.
- Avoid conflicts of interest — for example, selling an additive or a home unit you have recommended without disclosing your interest.
- Practise in a way that maintains public confidence in the profession, including in what you say about hydrotherapy publicly and online.



Professional misconduct under O. Reg. 544/94

Section 26 of O. Reg. 544/94 under the Massage Therapy Act, 1991 defines acts of professional misconduct. Several map directly onto hydrotherapy practice.

Conduct that engages s. 26

- Treating without informed consent
- Practising beyond the scope of practice or beyond your competence
- Failing to maintain the standard of practice of the profession
- Failing to keep records as required
- Failing to maintain a safe and sanitary practice environment

How this plays out in hydrotherapy

- Applying a modality you cannot explain the contraindications for
- Applying heat to an acutely inflamed or numb area without screening
- Leaving a client unattended during a systemic application
- Recording only 'hot pack' with no temperature, layering, checks or response
- Reusing a basin without disinfection, or reusing paraffin



Managing a safety incident properly

Requirement 9 of the Safety and Risk Management Standard: respond effectively to safety incidents to minimise harm to clients, document them, and disclose to relevant authorities to prevent future adverse events.

- 1 Stop and stabilise.** Remove the agent, manage the immediate harm, and keep the client safe and supported.
- 2 Assess.** Establish what happened, the extent of the injury, and whether medical assessment is needed now.
- 3 Disclose to the client.** Explain plainly what occurred, what you have done and what happens next. Do not minimise it.
- 4 Document contemporaneously.** Times, temperatures, layering, checks performed, what was observed, what was said and what was done.
- 5 Report and review.** Report internally and to relevant authorities as required; take the equipment out of service if implicated.
- 6 Change the system.** Identify what would prevent a recurrence and record the change made — this is the point of the requirement.



STRiVE, evidence-informed practice and jurisprudence

The quality assurance programme

- STRiVE is CMTO's quality assurance programme for registrants.
- It supports continuing competence across the career span rather than a fixed hours requirement.
- Registrants engage in self-assessment, learning and reflection against the Standards.
- The Career-Span Competencies named against each Standard — such as 'comply with legal requirements' and 'maintain a safe work environment' — are the framework this connects to.

Evidence-informed practice

- CMTO maintains guidance on evidence-informed practice for registrants.
- Hydrotherapy has a long traditional literature and a smaller controlled-trial evidence base.
- Describe what a modality does physiologically; do not overstate clinical outcomes.
- Where evidence is limited, say so — and let the client's goals, comfort and response guide the plan.
- The Online Jurisprudence Program covers the law and regulation applying to Ontario RMTs.



Keeping the client at the centre of a thermal treatment

What this looks like

- The treatment plan reflects the client's goals, not only your assessment findings.
- Comfort, dignity and warmth are treated as part of the treatment, not a courtesy.
- The client is given genuine choices, including the choice of no thermal component.
- Cultural, religious and personal preferences about exposure and touch are asked about, not assumed.
- Language and communication needs are accommodated.

Practical checks

- Did I ask what the client wants from today's session before choosing the modality?
- Did I check the room temperature and the client's warmth, not just the pack's?
- Did I explain what would happen before the client was undressed and draped?
- Did I check in during the application, not only afterwards?
- Would the client be able to describe to someone else what I did and why?



Which Standard answers which question

Question in the clinic

Can I use this modality at all? Am I competent?

What must I tell the client before applying it?

Do I need written consent here?

How do I clean the basin between clients?

How much of the client may be exposed?

What must I write in the record, and by when?

A client was burned — what now?

Can I recommend a product I sell?

Standard to consult

Standards & Rules index; Code of Ethics; Safety and Risk Management

Consent — Requirement 1, six elements

Consent — Requirement 3 (sensitive areas and gluteal muscles)

Infection Prevention and Control; PIDAC / Public Health Ontario guidance

Draping and Physical Privacy

Record Keeping; Consent Requirement 7; PHIPA

Safety and Risk Management — Requirement 9

Conflict of Interest; Code of Ethics



Case scenarios

Presentations

- A regular client says 'just do whatever you did last time' and closes their eyes.
- A client asks you to add an essential oil they brought from home to a foot bath.
- A client's partner attends and answers questions on the client's behalf.
- Mid-treatment you decide to add a contrast sequence that was not in the original plan.
- A client with limited English nods at everything you say.

What the Standards require

- Consent is required prior to and throughout every treatment; a standing preference is not consent for today.
- If you lack sufficient information about its risks and contraindications, consent cannot be obtained and it must not be used.
- Establish whether the client is capable; if capable, consent must come from the client.
- Modifying a treatment plan requires a fresh consent discussion before you proceed.
- Communication must be effective; use interpretation and check understanding by asking the client to restate.



Common errors and their corrections

The error

- Treating the intake form as the consent
- Explaining the modality only after the client is draped
- Recording the modality but not the dose
- Cleaning equipment 'at the end of the day'
- Reassuring a client that a modality 'can't do any harm'
- Discussing a client in a shared staff area

The correction

- The form supports the conversation; it does not replace it
- Explain and consent before the client undresses
- Record temperature, layers, site, duration, checks and response
- Disinfect equipment between clients and log maintenance
- State the actual risks — that is a required element of consent
- Confidentiality applies everywhere, including casual conversation



The standard against which your practice is judged

- A duty of care arises the moment you accept a client: you must act in their best interest and take reasonable steps to minimise risk.
- The measure is not your own intention but what a reasonable, competent RMT would have done in the same circumstances.
- That standard is defined by the CMTO Standards of Practice, the Code of Ethics, and the body of knowledge taught in accredited programmes — including this course.
- It applies to what you did, what you failed to do, and what you failed to find out before acting.
- Screening you did not perform, sensation you did not test and contraindications you did not know are all failures of the same duty.
- Documentation is how you demonstrate that the duty was met — an undocumented screen is, in practice, an unperformed screen.
- The duty continues after the client leaves: home-care advice, follow-up and the reassessment plan are all part of it.



Professional boundaries during long, warm applications

A quiet, warm, prolonged application creates exactly the conditions in which boundary drift begins. Recognise the risk and manage it deliberately.

Where drift begins

- Extended unstructured conversation while the client is passive and warm
- Self-disclosure by the therapist to fill the time
- Reduced formality because the treatment feels like a comfort measure rather than clinical work
- Touch that is not clearly connected to the treatment purpose
- Treating the application as an opportunity rather than an intervention

How to hold the boundary

- Keep the purpose explicit: state what you are doing and why, at each stage.
- Keep conversation client-centred and clinically relevant.
- Maintain draping and dignity even when the treatment is passive.
- Check in at intervals rather than filling silence.
- Comply with the Prevention of Sexual Abuse and Professional Boundaries Standards without exception — including written consent for sensitive areas.



Personal health information in hydrotherapy practice

Collecting

- CMTO's Standard on Collecting Personal Health Information requires collection to be client-centred and respectful, and cautions against over-collecting.
- Collect what you need to screen safely: relevant conditions, medications, sensation history, prior adverse reactions.
- Explain why you are asking — clients tolerate detailed screening far better when the reason is stated.
- Do not collect information you have no clinical use for.

Using, storing and disclosing

- PHIPA governs collection, use, disclosure, safeguarding and retention of personal health information in Ontario.
- Store records securely, whether paper or electronic, and control who can access them.
- Disclose only with consent or where the law requires it.
- Confidentiality applies to conversation as well as records — including in staff areas and online.
- The Privacy and Confidentiality Standard extends explicitly to maintaining confidentiality online.



Fees, billing, advertising and conflict of interest

Fees and billing

- Bill only for services actually provided, described accurately.
- Hydrotherapy delivered as part of a massage therapy treatment is billed as massage therapy — not as a separate service the RMT is not registered to provide.
- Do not bill an insurer for time the client spent unattended in a bath as though it were hands-on treatment.
- Receipts must accurately reflect the date, duration and nature of the service.

Advertising and conflict of interest

- Claims about hydrotherapy must be truthful, verifiable and not misleading — no promises of cure or detoxification.
- Do not use testimonials or claims that cannot be substantiated.
- Selling home units, salts or oils creates a conflict of interest that must be identified, disclosed and managed.
- The client must never feel that declining a purchase will affect their care.
- Social media posts about treatments are advertising and are subject to the same rules.



Collaboration, referral and the circle of care

Collaboration

- The Collaboration and Professional Relationships Standard governs how RMTs work with other health professionals.
- Communicate respectfully and share information within the circle of care where the client consents.
- Where another practitioner has advised against heat or cold, follow that advice and clarify directly rather than through the client.
- Recognise the limits of your role in a shared plan of care.

Referral

- Refer when a presentation falls outside your scope or your training.
- Refer a new or changing sensory deficit, an unexplained skin lesion, a suspected DVT, or any adverse reaction beyond the transient.
- State findings, not diagnoses: describe what you observed and why it warrants assessment.
- Document the finding, the advice, the client's response and any follow-up.
- Referral does not end the therapeutic relationship — continue with whatever remains safe.



Prescribing self-treatment is a professional act

Most of the value of hydrotherapy is realised between visits. Home-care advice carries the same professional obligations as treatment given in the clinic.

- Teach only techniques the client can perform safely without supervision.
- Give the same four parameters you would use yourself: what, where, how hot or cold, and for how long.
- Give explicit stop criteria: what the client should watch for and when to discontinue.
- Screen the home environment: does the client have a thermometer, safe water temperature, non-slip flooring, someone nearby?
- Adapt for the client's own risk factors — a client with neuropathy should not be dosing their own foot bath by feel.
- Obtain consent for home care as you would for in-clinic treatment, including the risks.
- Record exactly what you advised, in the words the client was given, and follow it up at the next visit.
- Provide written instructions where the sequence is complex, such as contrast bathing.



Consent and supervision in the teaching clinic

What must be disclosed

- That the treatment is being provided by a student, under supervision, as part of an educational programme.
- Who the supervising instructor is and that they may observe or intervene.
- That another student may be present as an observer or partner, and the client may decline.
- That the treatment record forms part of the client's health record and part of the student's assessment.

How this course applies it

- Practical sessions run in trios — two students plus instructor at a practical station.
- Each partner is screened and consented exactly as a clinic client would be, every time.
- Sensation testing and skin inspection are performed in full, not simulated.
- Adverse responses in practice sessions are documented and reported like any clinical incident.
- Practise it the way you will be examined — and the way you will practise.



A hydrotherapy record that meets the standard

Compare this with 'hot pack to low back, 15 min'. The difference is what makes the treatment defensible.

Element	Recorded as
Screening	Lumbar skin intact, no lesion or oedema. Hot/cold and sharp/dull discrimination accurate bilaterally L1–L5 region. No DVT indicators. No cardiac history.
Reasoning	Chronic non-inflammatory lumbar tension; heat indicated to increase extensibility prior to manual treatment.
Consent	Modality, temperature, duration, risk of redness or burn, and alternative of manual warming discussed. Client consented verbally; advised to report any stinging or increased discomfort.
Application	Hydrocollator pack, tank 74 °C, 8 toweling layers, mid-lumbar, client supine with pack over — not under. 15 minutes.
Monitoring	Skin checked at 4 min: even pink, comfortable. Checked at 10 min: unchanged. On removal: even erythema, no blistering or mottling.
Response	Client reports reduced lumbar tightness; palpable reduction in paraspinal tone. No adverse reaction.
Home care	Advised moist heat 15 min once daily, comfortably warm, always with a towel layer; stop for blotchy skin or increased pain.
Plan	Reassess response at next visit; consider contrast if stiffness persists.



Describing hydrotherapy honestly to clients

- Describe mechanisms you can defend: vasodilation, vasoconstriction, altered nerve conduction, increased tissue extensibility, analgesia.
- Avoid claims of detoxification, toxin removal or immune boosting — these are not supported and are advertising risks as well as ethical ones.
- Distinguish 'this is likely to help you feel more comfortable and move more easily' from 'this will heal your injury'.
- Where the evidence is limited, say so plainly; clients respond well to honesty and poorly to being corrected later.
- Traditional use is a legitimate reason to consider a modality, but it is not the same as evidence of effect — name which you are relying on.
- Set expectations about duration of effect: most thermal effects are short-lived and support other treatment rather than replacing it.
- Consent requires the client to understand the expected benefits accurately — overstatement undermines the validity of the consent itself.



What happens when a client raises a concern

The process

- Anyone may file a complaint with CMTO about the conduct or care of an RMT.
- Complaints are investigated by the Inquiries, Complaints and Reports Committee, which may take a range of actions.
- Serious matters may be referred to a Discipline hearing, and decisions are published.
- Mandatory reports — including reports of sexual abuse by a health professional — must be filed as required by law.
- Zero tolerance for abuse is CMTO policy and is publicly communicated to clients.

What protects you

- Screening performed and recorded
- Consent discussed, obtained and documented within 24 hours
- Dose, layering, checks and response recorded specifically
- Equipment maintenance and cleaning logged
- Incidents disclosed, documented and acted on
- Practising only what you are trained and competent to deliver
- In every case, the contemporaneous record is the strongest evidence available to you



Where the framework meets the modality

Every remaining lecture in this course applies this framework to a specific modality. Note now which obligation each one will stress.

- **Local moist heat (Lecture 5)** — layering, positioning, equipment maintenance and the equipment service log.
- **Paraffin and steam (Lecture 6)** — skin integrity screening, single-use barriers, temperature verification and infection control.
- **Mechanical applications (Lecture 7)** — draping, dignity, avoidance of sensitive areas and per-client equipment hygiene.
- **Cold applications (Lecture 8)** — barrier layers, time ceilings, and screening for abnormal cold responses by history.
- **Contrast therapy (Lecture 9)** — consent reverified between cycles, and screening against both heat and cold contraindications.
- **Additives and systemic work (Lecture 10)** — allergy screening, patch testing, WHMIS, continuous supervision and health-history depth.



Can you answer these from memory?

- What is CMTA's mandate, and how does it differ from the RMTA's?
- State the six elements of the consent discussion required by CMTA.
- What must you do if you lack sufficient information about a modality's risks and contraindications?
- Within what period must consent conversations be documented?
- Which areas require written informed consent before assessment or treatment?
- Name four Requirements from the Safety and Risk Management Standard.
- What must you do if a client is incapable and no substitute decision-maker is available?
- Name three hydrotherapy practices that could constitute professional misconduct.



Carry these into the clinic

- CMTO regulates massage therapy in Ontario to protect the public; its Standards set the minimum expectations for every RMT.
- Practise within scope and within your own demonstrated competence — and refer when a presentation exceeds either.
- Consent is obtained before and throughout treatment, covers six required elements, and is documented within 24 hours.
- If you cannot explain a modality's risks and contraindications, you cannot consent a client to it, and you must not use it.
- The practice setting and all equipment must be safe, sanitary, cleaned, disinfected and logged.
- Draping, privacy, dignity and warmth are part of the treatment, not a courtesy.
- Document modality, dose, checks, response and home care — the record is the evidence of competent practice.
- Respond to safety incidents by stabilising, disclosing, documenting, reporting and changing the system.



Prescribed and recommended reading

Cited throughout this deck in the source line at the foot of each slide. Instructors will indicate the specific chapters that serve as directed reading for each day.

Books — full citations

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Werner, R. (2019). *A Massage Therapist's Guide to Pathology* (7th ed.). Philadelphia, PA: Wolters Kluwer. [Pathology-driven contraindication screening.]

Books — continued

Cameron, M. H. (2018). *Physical Agents in Rehabilitation: An Evidence-Based Approach to Practice* (5th ed.). St. Louis, MO: Elsevier. [Thermal physics, thermotherapy and cryotherapy evidence base.]

Tortora, G. J. & Derrickson, B. (2020). *Principles of Anatomy and Physiology* (16th ed.). Hoboken, NJ: Wiley. [Program-wide prescribed text — integument, circulation, thermoregulation.]

Norris, T. L. (2019). *Porth's Essentials of Pathophysiology* (5th ed.). Philadelphia, PA: Wolters Kluwer. [Program-wide prescribed text — inflammation, vascular and neuropathic conditions.]

Kisner, C., Colby, L. A. & Borstad, J. (2017). *Therapeutic Exercise: Foundations and Techniques* (7th ed.). Philadelphia, PA: F. A. Davis. [Program-wide prescribed text — tissue healing stages and heat-assisted stretch.]

Biel, A. (2019). *Trail Guide to the Body* (6th ed.). Boulder, CO: Books of Discovery. ISBN 978-0-9987850-6-6. [Program-wide prescribed text — surface anatomy for application sites.]



Regulatory sources, legislation and links

All CMTO Standards of Practice were approved 9 February 2021 and published in the 2022 Standards of Practice set. Verify currency at [cmto.com](https://www.cmto.com) before relying on any Standard in practice.

Regulatory sources and web links

College of Massage Therapists of Ontario. Standards & Rules.
<https://www.cmto.com/rmts/standards-and-rules/>

CMTO. Standard of Practice: Safety and Risk Management (approved 9 Feb 2021; published 2022). <https://www.cmto.com/rules/standard-of-practice-safety-and-risk-management/>

CMTO. Standard of Practice: Consent (approved 9 Feb 2021; published 2022).
<https://www.cmto.com/rules/consent/>

CMTO. Standard of Practice: Infection Prevention and Control.
<https://www.cmto.com/rules/standard-of-practice-infection-prevention-and-control/>

CMTO. Record Keeping. <https://www.cmto.com/rules/record-keeping/>

CMTO. Standard of Practice: Draping and Physical Privacy.
<https://www.cmto.com/rules/standard-of-practice-draping-and-physical-privacy/>

CMTO. Standard of Practice: Client-centred Care.
<https://www.cmto.com/rules/client-centred-care/>

CMTO. Code of Ethics. <https://www.cmto.com/rules/code-of-ethics/>

Legislation, guidance and competency frameworks

Massage Therapy Act, 1991, S.O. 1991, c. 27.
<https://www.ontario.ca/laws/statute/91m27>

O. Reg. 544/94 (Professional Misconduct, s. 26) under the Massage Therapy Act, 1991. <https://www.ontario.ca/laws/regulation/940544>

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A.
<https://www.ontario.ca/laws/statute/96h02>

Regulated Health Professions Act, 1991, S.O. 1991, c. 18.
<https://www.ontario.ca/laws/statute/91r18>

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sch. A.
<https://www.ontario.ca/laws/statute/04p03>

Public Health Ontario / PIDAC. Routine Practices and Additional Precautions in All Health Care Settings. <https://www.publichealthontario.ca/-/media/documents/b/2012/bp-rpap-healthcare-settings.pdf>

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FOMTRAC. Inter-Jurisdictional Practice Competencies and Performance Indicators (Sept 2016). <https://www.fomtrac.ca/wp-content/uploads/2016/10/FOMTRAC-PCs-PIs-September-2016.pdf>