College of Massage Therapists of Ontario

Standards of Practice Project

Document.1
Survey Consultation Report

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EXECUTIVE SUMMARY

Background

The College of Massage Therapists of Ontario (CMTO) is the regulator established by the provincial government to regulate the practice of Massage Therapy and to govern the conduct of Registered Massage Therapists (RMTs) through the provisions of the *Regulated Health Professions Act (1991)* (RHPA) and the *Massage Therapy Act (1991)*. CMTO's current Standards of Practice (Standards), which outline the expectations for professional practice of RMTs, were developed in 2006. In September 2019, CMTO initiated a project and hired a consulting firm, Parker-Taillon Consulting Inc., to assist with a review of the Standards. The Standards of Practice Advisory Group (SPAG) composed of representative members of CMTO (drawing upon RMTs from a diverse group of practice settings, experience and geographic locations) was established to provide input into the process. One specific area of focus for the SPAG was on developing Standards that could be implemented by the profession regardless of practice setting.

Over approximately 17 months, the project involved the following key steps:

1. Conducting an environmental scan;
2. Development of Draft 1 of the Standards;
3. Virtual meetings with the SPAG to review Draft 1 of the Standards and develop Draft 2;
4. Stakeholder consultation to validate Draft 2 of the Standards using an electronic survey; and
5. Completion of a final Standards document and final report.

The purpose of this Report is to provide the results of the stakeholder consultation on Draft 2 of the Standards using an on-line survey (Step 4).

Approach

The invitation to participate in the survey was distributed to a total of 15,055 RMTs, 136 stakeholders, and 15 CMTO Council members. Ontario's Citizen Advisory Group was also made aware of the consultation and invited to participate. The survey was also publicized to the public via social media. All potential participants were sent an email on October 1, 2020, that included a link to the Standards of Practice consultation page. The survey was open from October 1 to November 16, 2020. It is of particular note that this survey was conducted during the global COVID-19 pandemic that may have had an impact on the number and nature of the responses.

Results

A total of 1624 individuals opened the survey and responded to the initial question related to type of respondent. The largest group was CMTO registrants who represented 93.41% of survey respondents and approximately 9.98% of CMTO registrants. Of note was the relatively high response rate of members of the public/clients who responded to the survey with 63 respondents, representing 3.88% of all respondents. For the most part, the characteristics of the CMTO registrant respondents, in terms of primary practice setting and years of experience, generally reflected the CMTO registrant data for a similar time period.

The *response rate* for each Standard varied throughout the survey and ranged from 631 (Client-centred Care) to 216 (Safety and Risk Management), with an average rate of 321. This differential could be due to certain Standards being of more interest to respondents, such as Client-centred Care. Even though respondents could select which Standards they wished to respond to, a progressively diminishing number of respondents was noted towards the end of

the Standard document, which could possibly reflect an element of survey fatigue in participants, which is not unusual for a survey of this length.

The percentage of respondents who indicated that a specific Standard was *all easy to understand* ranged from 83.99% (Acupuncture) to 95.95% (Privacy and Confidentiality), with an average of 89%, indicating that overall, the large majority of respondents had no difficulty understanding the Standards. These findings also highlighted that five of the Standards, where only approximately 85% of respondents indicated the Standard was all easy to understand, required further consideration to identify a few specific issues which may have affected the Standard's clarity (i.e., Acupuncture, Client-centred Care, Collaboration and Professional Relationships, Fees and Billing, Prevention of Sexual Abuse).

The percentage of respondents who indicated that a specific Standard was *all easy to implement* ranged from 87.00% (Collaboration and Professional Relationships) to 97.73% (Privacy and Confidentiality), with an average of 93%. All of the Standards, with the exception of Collaboration and Professional Relationships, received an over 90.00% positive rating in terms of their ability to be implemented.

A number of *general comments* were also received and included: positive feedback on the Standards; questions about terminology; repetition of feedback received on individual Standards; and comments related to repetition throughout the Standards generally, and specifically repetition of consent and consent for sensitive areas.

In *summary*, these positive findings indicated that overall, survey respondents felt Draft 2 of the Standards was clear, easy to understand and possible to implement in a broad range of practice settings. The slightly lower *all easy to understand* ratings compared to the *all easy to implement* scores may have reflected the respondents' focus on ensuring clarity on a few specific issues as mentioned earlier. The valuable feedback provided was useful to further enhance the clarity and applicability of the Standards.

Development of the Draft Final Standards

This report summarizes the results of the stakeholder consultation on the CMTO Standards of Practice and highlights aspects for further consideration. Steps to develop the Draft Final Standards included:

- Meeting with SPAG to obtain their input into the changes that should be made to Draft 2 of the Standards in light of the stakeholder survey results (Dec. 2020).
- Revision of the Standards based on SPAG discussions to become Draft 3 (Dec. 2020).
- Review of Draft 3 by Legal Counsel (Dec. 2020/Jan. 2021).
- Mini-consultation to obtain feedback on the revised Draping Standard (renamed Draping and Physical Privacy) and revision of the Standard in consultation with Legal Counsel (January 2021).
- Presentation of Draft 3 to the Quality Assurance Committee (Jan. 2021).
- Submission of Standards for Council approval (Feb. 2021).

1.0 INTRODUCTION/BACKGROUND

The College of Massage Therapists of Ontario (CMTO) is the regulator established by the provincial government to regulate the practice of Massage Therapy and to govern the conduct of Registered Massage Therapists (RMTs) through the provisions of the *Regulated Health Professions Act (1991)* (RHPA) and the *Massage Therapy Act (1991)*. CMTO has over 14,000 registrants and has been regulating the Massage Therapy profession in the province of Ontario since 1994.[1]

CMTO's current Standards of Practice (Standards), which outline the expectations for professional practice of RMTs, were developed in 2006. In September 2019, CMTO initiated a project to review and update the CMTO Standards to reflect current needs and trends. CMTO hired a consulting firm, Parker-Taillon Consulting Inc., to assist with this work. The Consultants worked closely with CMTO staff throughout the project. The Standards of Practice Advisory Group (SPAG) composed of representative members of CMTO (drawing upon RMTs from a diverse group of practice settings, experience and geographic locations) was established to provide input into the process. One specific area of focus for the SPAG was on developing Standards that could be implemented by the profession regardless of practice setting.

Over approximately 17 months, the project involved the following key steps:
1. Conducting an environmental scan;
2. Development of Draft 1 of the Standards;
3. Virtual meetings with the SPAG to review Draft 1 of the Standards and develop Draft 2;
4. Stakeholder consultation to validate Draft 2 of the Standards using an electronic survey; and
5. Completion of a final Standards document and final report.

The purpose of this Report is to provide the results of the stakeholder consultation on Draft 2 of the Standards using an electronic survey (Step 4).

2.0 SURVEY CONSULTATION APPROACH

The stakeholder survey consultation on the Standards involved two major activities including:
1. on-line survey of all CMTO registrants and key external stakeholders, and
2. analysis and Survey Consultation Report preparation.

Details with respect to each of these activities are provided in this section and the results are presented in Section 3.0.

It is of particular note that this survey was conducted during the global COVID-19 pandemic which may have had an impact on the number and nature of the responses.

Activity 1. On-line Survey

An on-line survey using the SurveyMonkey platform was used to obtain stakeholder feedback on Draft 2 of the Standards. CMTO staff developed the survey in consultation with the project Consultants.

[1] College of Massage Therapists of Ontario. (2019) *About the College Webpage*. Retrieved from: https://www.cmto.com/about-the-college/

The survey included three sections:

- demographic information about respondents,
- feedback on each of the Standards, and
- a question to obtain general feedback on the Standards.

To obtain feedback on each of the Standards, respondents were asked the four questions outlined in Table 1.

Table 1 Survey Questions for Each of the Standards

1. Is there any part of the draft Standard (name of the Standard) that is difficult to understand?
   - ❑ Yes, there is at least one part that is difficult to understand
   - ❑ No, it is all easy to understand

   If respondents indicated yes – they were taken to a separate page where they could indicate which part was difficult to understand and provide comments.

2. Is there any part of the draft Standard (name of the Standard) that is not possible to implement?
   - ❑ Yes, there is at least one part that is not possible to implement
   - ❑ No, it is all possible to implement

   If respondents indicated yes – they were taken to a separate page where they could indicate which part was not possible to implement and provide comments.

3. Is there anything missing from the draft Standard (name of the Standard) that should be added?
   - ❑ No, all the minimum expectations for Standard (name of the Standard) are covered
   - ❑ Yes, please add (and why)

4. Please share any additional feedback or comments on the draft Standard (name of the Standard).

The invitation to participate in the survey consultation was distributed to a total of 15,055 RMTs, 136 stakeholders, and 15 CMTO Council members, and to members of the public via social media and the Citizen Advisory Group (via newsletter). All potential participants were sent an email on October 1, 2020, that included a link to the Standards of Practice consultation page. The survey was open from October 1 to November 16, 2020. A total of four reminder emails and social media (twitter) were used to encourage completion of the survey.

Activity 2. Analysis and Survey Consultation Report Preparation

CMTO staff and the Consultants worked collaboratively to analyze both the quantitative and the qualitative results from the on-line survey and other responses received. The comments provided on each Standard were content analyzed for key themes that are presented in Appendix A and summarized in this Report.

The Consultants prepared a draft Survey Consultation Report and submitted it to CMTO staff for feedback. The Consultants then revised and prepared this final Survey Consultation Report.

3.0 SURVEY CONSULTATION RESULTS AND ANALYSIS

3.1 Response Rate and Demographic Profile of Respondents

The number and profile of individuals who completed the initial survey question related to type of respondent is presented in Table 2.

Table 2 Responses to Initial Survey Question re. Type of Respondent	
Type of Respondent	**% (n)[2]**
Massage Therapist CMTO Registrants (General or Inactive)	93.41% (1517)
Member of the Public/Client	3.88% (63)
Massage Therapy Student or Candidate	0.92% (15)
Other (please specify)	0.86% (14)
Other Healthcare Professional	0.68% (11)
Educator (Non-Massage Therapist)	0.18% (3)
Employer	0.06% (1)
TOTAL	100.00% (1624)

A total of 1624 individuals opened the survey and responded to the initial question related to type of respondent. It should be noted that with the format of the survey, respondents were able to select which Standards they wished to comment on. As a result, the response rate for each of the survey questions related to the Standards varied and was considerably less than for the initial question. Details are described in Section 3.2.1.

Not surprisingly, CMTO registrants (general or inactive) were the largest group of respondents, representing 93.41% of the total and approximately 9.98% of all CMTO registrants. Of note, is that the second ranking group of respondents was members of the public/clients with 63 respondents, representing 3.88% of the total number of respondents. The other types of respondents combined represented 2.70% of the total number of respondents and included educators (who were not massage therapists), massage therapy students/candidates, other health care professionals, employers and other.

The profile of CMTO registrants who completed the demographic questions related to primary practice setting and years of experience compared to CMTO registrant data for a similar time period is provided in Table 3.

Table 3 Comparison of CMTO Registrants who Completed the Demographic Questions to CMTO Registrant Data for Primary Practice Setting and Years of Experience		
Respondent Characteristics	**On-line survey % (n)[3]**	**CMTO Data Nov.25/20 % (n)**
Primary Practice Setting		
Clinic which I am the only provider	13.86% (207)	8.81% (1318)
Clinic with other health care professionals (e.g. Chiropractors)/ Clinic with other RMTs only	53.85% (804)	39.91% (5969)
Education facility	1.27% (19)	0.43% (64)
Health club/Gym/Fitness and wellness studio	1.07%(16)	1.10% (164)

[2] Note: The percentages may not add up to 100% due to rounding
[3] Note: The percentages may not add up to 100% due to rounding.

Table 3 Comparison of CMTO Registrants who Completed the Demographic Questions to CMTO Registrant Data for Primary Practice Setting and Years of Experience		
Respondent Characteristics	**On-line survey % (n)[3]**	**CMTO Data Nov.25/20 % (n)**
Home practice	16.28% (243)	17.06% (2551)
Hospital/Rehabilitation facility/Congregate care facility/Mental health and Addiction Facility	0.60% (9)	4.41% (659)
Mobile practice	3.82% (57)	2.05% (307)
Spa	7.17% (107)	8.63% (1291)
Other practice setting (please specify)	2.07% (26)	17.6% (2633)[4]
TOTAL	100%(1493)	100% (14,956)
Years of Experience		
11+ years	47.42% (708)	46.44% (6946)
6-10 years	25.25% (377)	24.55% (3672)
1-5 years	23.64% (353)	26.12% (3907)
Less than 1 year	3.68% (55)	2.89% (431)
TOTAL	100% (1493)	100% (14956)

A comparison of the data for *primary practice setting* demonstrates that the survey respondents were largely representative of the CMTO registrant data characteristics. The relative percentages of survey respondents and CMTO registrant data were within 5% of each other with two exceptions:

- The percentage of RMT survey respondents who indicated they work in a "Clinic with other health care professionals (e.g., Chiropractors) / Clinic with other RMTs only" was higher than the CMTO registrant data.
- The percentage of RMT survey respondents who indicated "other practice setting" was lower than the CMTO registrant data. This may be partially explained by the CMTO registrant data for "other practice setting" that included registrants who did not indicate a practice setting, as well as inactive registrants. While in the survey, inactive registrants were able to indicate a practice setting.

If the "other practice setting" category is not included, the rank ordering of the top four categories for primary practice setting (i.e., Clinic with other health care professionals / Clinic with other RMTS only, Home Practice, Clinic which I am the only provider and Spa) is the same for survey respondents and the CMTO registrant data and represents 91.45% of the survey respondents.

The results for the *years of experience* of the survey respondents, were also relatively similar to the CMTO registrant data. The relative percentages were within 1.00% of each other, with the exception of the category "1-5 years of experience" where the difference was 2.48%. In terms of the rank ordering of the years of experience categories, the largest majority of both survey respondents and the CMTO registrant data had 11 or more years of experience (47.42% and 46.44% respectively). The second and third ranked categories were reversed due to a slight under representation in the category of "1-5 years or experience" of survey respondents (23.64%) compared to the CMTO registrant data (26.12%). The category of "less than 1 year of experience" ranked fourth for both survey respondents and the CMTO registrant data.

[4] Note: The number for "other practice setting" in the CMTO data included registrants who did not indicate a practice setting and inactive registrants. For the survey, inactive registrants were able to indicate a practice setting.

In addition to the survey data, other types of feedback on Draft 2 of the Standards were received from various groups and individuals as outlined in Table 4.

Table 4 CMTO Standards Consultation: Other types of feedback received

Type of Feedback	No. of Individuals Involved
• Client Relations Committee Comments	4
• Email from Chair of Registered Massage Therapists' Association of Ontario	N/A
• Email from QA Program Consultants	2
• Emails from Individual RMTs	5
• Hard copy of Survey	1
• Letter co-signed by RMTs	86

In summary, a total of 1624 individuals opened the survey and responded to the initial question related to the type of respondent. The majority of the respondents were CMTO registrants who generally reflected the CMTO registrant data for a similar time period in terms of primary practice setting and years of experience. Of note, was the number of members of the public who responded to the survey.

3.2 Feedback on Standards

3.2.1 Overview of Results

The overview of the response rate by Standard, and how each Standard was rated in terms of the understandability and implementability is outlined in Table 5.

Table 5 Overview of Results for Each Standard

Column 1	Column 2 Number of Respondents Indicating They Want to Share Feedback on the Standard[5]	Column 3 Respondents Indicating the Standard is "All Easy to Understand"	Column 4 Respondents Indicating the Standard is "All Possible to Implement"
Acupuncture	306	83.99% (257 out of 306 responses)	91.39% (244 out of 267 responses)
Client-centred Care	631	85.50% (513 out of 600 responses)	91.64% (504 out of 550 responses)
Collaboration and Professional Relationships	384	86.08% (334 out of 388 responses)	87.00% (328 out of 377 responses)
Communication	306	93.83% (289 out of 308 responses)	96.64% (288 out of 298 responses)
Conflict of Interest	294	87.76% (258 out of 294 responses)	96.50% (276 of 286 responses)
Consent	386	87.92% (342 out of 389 responses)	92.65% (353 out of 381 responses)

[5] Note: The total number of respondents in Column 2 can differ from the number in Columns 3 and/or 4 as some individuals who originally indicated they wished to provide feedback to the Standard may have failed to do so. Conversely, those who indicated they did not wish to provide feedback did indeed answer questions related to the Standards' understandability and implementability.

Table 5 Overview of Results for Each Standard			
Column 1	**Column 2** **Number of Respondents Indicating They Want to Share Feedback on the Standard[5]**	**Column 3** **Respondents Indicating the Standard is "All Easy to Understand"**	**Column 4** **Respondents Indicating the Standard is "All Possible to Implement"**
Draping	292	89.00% (259 out of 291 responses)	90.28% 260 out of 288 responses)
Fees and Billing	288	85.62% (250 out of 292 responses)	93.73% (269 out of 287 responses)
Infection Prevention and Control	300	92.38% (279 out of 302 responses)	93.60% (278 out of 297 responses)
Prevention of Sexual Abuse	293	84.75% (250 out of 295 responses)	96.25% (282 out of 293 responses)
Privacy and Confidentiality	220	95.95% (213 out of 222 responses)	97.73% (215 out of 220 responses)
Professional Boundaries	264	89.02% (235 out of 264 responses)	91.22% (239 out of 262 responses)
Safety and Risk Management	216	94.95% (207 out of 218 responses)	97.22% (210 out of 216 responses)

As previously noted, the *response rate* per Standard varied throughout the survey. The total number of respondents who indicated they wished to provide feedback on a Standard (Table 5 – Column 2) ranged from 631 (Client-centred Care) to 216 (Safety and Risk Management), with an average response rate of 321. The differential in response rate per Standard could be due to certain Standards being of more interest to respondents, such as Client-centred Care. Even though respondents could select which Standards they wished to respond to, a progressively diminishing number of respondents was noted towards the end of the Standard document. This could possibly reflect an element of survey fatigue in participants, which is not unusual for a survey of this length.

The percentage of respondents who indicated that the Standard was *all easy to understand* (Table 5 – Column 3) ranged from 83.99% (Acupuncture) to 95.95% (Privacy and Confidentiality), with an average of 89%, indicating that overall, the large majority of respondents had no difficulty understanding any elements in the Standards. These findings also highlighted that five of the Standards, where only approximately 85% of respondents indicated the Standard was all easy to understand, required further consideration to identify a few specific issues which may have affected the Standard's clarity (i.e., Acupuncture, Client-centred Care, Collaboration and Professional Relationships, Fees and Billing, Prevention of Sexual Abuse).

The percentage of respondents who indicated that the Standard was *all easy to implement* (Table 5 – Column 4) ranged from 87.00% (Collaboration and Professional Relationships) to 97.73% (Privacy and Confidentiality), with an average of 94%. All of the Standards, with the exception of Collaboration and Professional Relationships received an over 90.00% positive rating in terms of their ability to be implemented.

These positive findings reinforced that overall, survey respondents felt Draft 2 of the Standards was clear, easy to understand and possible to implement in a broad range of practice settings. The slightly lower *all easy to understand* ratings compared to the *all easy to implement* scores may have reflected the respondents' focus on ensuring clarity on a few specific issues as

mentioned earlier. The valuable feedback provided was useful to further enhance the clarity and applicability of the Standards. The key themes identified in the feedback are outlined in Appendix A.

The remainder of this section of the Report includes details regarding the response rate and a summary of the key themes raised in the feedback for each Standard, as well as the general comments question. *It should be noted that the specific Requirement numbers included in this section refer to Draft 2 of the Standards that was used for the consultation*.

3.2.2 Acupuncture

Acupuncture Response Rate

The total responses, demographics of respondents and response rate to the questions on the Acupuncture Standard are summarized in Table 6.

Table 6 Acupuncture Standard Response Rate for Questions	
Total responses: 306	
Demographics of Respondents: RMT: 275; Public: 19; Educator: 1; Student/Candidate: 3; Other healthcare prof: 6	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	83.99% (257 of 306 responses)
Respondents indicating the Standard is all possible to implement	91.39% (244 of 267 responses)

Overall, this Standard had one of the lowest positive response rates related to understandability. This could be due to the fact that only a small proportion of CMTO registrants practice acupuncture and therefore there were elements of the Standard they may not have understood. However, the results indicated that 83.99% of the respondents who provided feedback on this Standard felt it was easy to understand and 91.39% that it was possible to implement.

Acupuncture Feedback Summary of Key Themes

The feedback provided on the Acupuncture Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Question as to whether acupuncture was within the Scope of Practice for RMTs.
- Confusion as some parts applied to all RMTs, others only to RMTs performing acupuncture.
- More information related to skin disinfection procedures with acupuncture needed.
- Questions about insurance, annual declaration requirements and consent when referring clients to another RMT.

3.2.3 Client-centred Care

Client-centred Care Response Rate

The total responses, demographics of respondents and response rate to the questions on the Client-centred Care Standard are summarized in Table 7.

Table 7 Client-centred Care Standard Response Rate for Questions	
Total responses: 632	
Demographics of Respondents: RMT: 602; Public: 22; Educator: 1; Student/Candidate: 3; Other healthcare prof: 4	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	85.50% (513 out of 600 responses)
Respondents indicating the Standard is all possible to implement	91.64% (504 out of 550 responses)

Overall, this Standard had the highest response rate with 632 respondents, 22 of which were members of the public. This may reflect the commitment of RMTs to client-centred care, as well as the interest of the public to determine what they can expect from care from RMTs. This Standard had 85.50% of respondents who stated the Standard was easy to understand and 91.64% who felt that it was possible to implement. This Standard had one of the lowest approval rates related to understandability which could be due several reasons outlined below.

Client-centred Care Feedback Summary of Key Themes

The feedback provided on the Client-centred Care Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Questions and concerns that the term *client-centred care* was not defined and not used appropriately; there was no reference to the importance of client input, a key tenant of client-centred care; and the Standard itself was more RMT focused than client focused.
- Concern and frustration with repetition across the Standards related to consent, sensitive areas, sexual abuse and professional boundaries.
- Confusion related to written consent for sensitive areas, why the difference between breasts and gluteal muscles/buttocks, and concern that seeking repeated consent is disruptive, time-consuming and awkward.
- Questions about how practising within scope is related to client-centred care (Requirement #5), client discharge/discontinuation (Requirement #14) and consent for record transfer and fees. (Requirement #17)

3.2.4 Collaboration and Professional Relationships

Collaboration and Professional Relationships Response Rate

The total responses, demographics of respondents and response rate to the questions on the Collaboration and Professional Relationships Standard are summarized in Table 8.

Table 8 Collaboration and Professional Relationships Standard Response Rate for Questions	
Total responses: 384	
Demographics of Respondents; RMT: 378; Public: 3; Educator: 1; Student/Candidate: 2; Other healthcare prof: 0	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	86.08% (334 of 388 responses)
Respondents indicating the Standard is all possible to implement	87.00% (328 of 377 responses)

The results indicated that 86.08% of the respondents who provided feedback on this Standard felt it was easy to understand and 87.00% it was possible to implement. This Standard had one

of the lowest ratings for understandability and implementability, possibly due to several reasons outlined below.

Collaboration and Professional Relationships Feedback Summary of Key Themes
The feedback provided on the Collaboration and Professional Relationships Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Clarify which requirements apply only within the circle of care or "formal collaborations."
- Wording related to "aligning treatment plan" was understood by some respondents to mean that the RMT should yield to other health care professionals' treatment plans, regardless of their assessment and professional knowledge. (Requirement #1)
- Confusion regarding sharing client information within the circle of care and issues of privacy and confidentiality. (Requirement #3)
- Wording regarding the RMT role in resolving "problems or conflicts between those involved in the client's care" was too vague. (Requirement #4)

3.2.5 Communication

Communication Response Rate
The total responses, demographics of respondents and response rate to the questions on the Communication Standard are summarized in Table 9.

Table 9 Communication Standard Response Rate for Questions	
Total responses: 306	
Demographics of Respondents: RMT: 297; Public: 7; Educator: 1; Student/Candidate: 0; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	93.83% (289 of 308 responses)
Respondents indicating the Standard is all possible to implement	96.64% (288 of 298 responses)

This Standard had very high ratings with 93.83% of the respondents who provided feedback on this Standard felt it was easy to understand and 96.64% that it was possible to implement.

Communication Feedback Summary of Key Themes
The feedback provided on the Communication Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Needs more of a client-centred focus, RMTs "have an obligation to create the conditions necessary for creating autonomous choice."
- Needs to acknowledge client's uniqueness and culture. (Requirement #3)
- Concern that all clients may not be able to communicate directly with the RMT and the need for a third party, when necessary to assist. (Requirement #3)

3.2.6 Conflict of Interest

Conflict of Interest Response Rate
The total responses, demographics of respondents and response rate to the questions on the Conflict of Interest Standard are summarized in Table 10.

Table 10 Conflict of Interest Standard Response Rate for Questions	
Total responses: 294	
Demographics of Respondents: RMT: 288; Public: 3; Educator: 1; Student/Candidate: 1; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	87.76% (258 of 294 responses)
Respondents indicating the Standard is all possible to implement	96.50% (276 of 286 responses)

The results indicated that 87.76% of the respondents who provided feedback on this Standard felt it was easy to understand and 96.50% that it was possible to implement.

Conflict of Interest Feedback Summary of Key Themes

The feedback provided on the Conflict of Interest Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Questions about referral fees and are they always a conflict of interest? (Requirement #1)
- Unclear about what revenue sharing includes and excludes. (Requirement #3)
- Questions about rental agreements and conflict of interest. (Requirement #4)

3.2.7 Consent

Consent Response Rate

The total responses, demographics of respondents and response rate to the questions on the Consent Standard are summarized in Table 11.

Table 11 Consent Standard Response Rate for Questions	
Total responses: 386	
Demographics of Respondents: RMT: 373; Public: 9; Student/Candidate: 2; Other healthcare prof: 2	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	87.92% (342 out of 389 responses)
Respondents indicating the Standard is all possible to implement	92.65% (353 out of 381 responses)

The results indicated that 87.92% of the respondents who provided feedback on this Standard felt it was easy to understand and 92.65% that it was possible to implement.

Consent Feedback Summary of Key Themes

The feedback provided on the Consent Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Similar issues and confusion related to written consent for sensitive areas as noted in Client-centred Care; in addition, the concern that COVID-19 Infection Prevention and Control (IPAC) protocols are barriers to safely obtaining repeated written consent. (Requirement #3)
- Questions about determining capacity of clients and verification of substitute decision-maker. (Requirement #5)
- Confusion around monitoring/verifying consent. (Requirement #6)
- Questions around the implications of consent and documentation, as well as the electronic health record.

3.2.8 Draping

Draping Response Rate

The total responses, demographics of respondents and response rate to the questions on the Draping Standard are summarized in Table 12.

Table 12 Draping Standard Response Rate for Questions	
Total responses: 292	
Demographics of Respondents: RMT: 283; Public: 6; Educator: 1; Student/Candidate: 1; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	89.00% (259 out of 291 responses)
Respondents indicating the Standard is all possible to implement	90.28% 260 out of 288 responses)

The results indicated that 89.00% of the respondents who provided feedback on this Standard felt it was easy to understand and 90.28% that it was possible to implement. Despite the positive support for this Standard, there was a substantial number of comments provided.

Draping Feedback Summary of Key Themes

The feedback provided on the Draping Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Concerns that this Standard does not take into account that many clients are treated or choose to be treated clothed (e.g., sports situations), clients have their own perceptions of what are sensitive areas for draping and the Standard is not client-centred.
- Questions around how sensitive areas and draping apply to the chest area of men.
- The term “privacy” in the Client Outcome is not in keeping with the definition in the Glossary.
- Repetition of consent and how this is related to draping. (Requirement #1)
- Questions around requesting consent every time client is undraped, gauging client’s comfort related to draping and the exposure of areas during certain procedures.
- Concerns that reaching under draping is sometimes required in certain situations (e.g., side lying, lying on back, to secure the drape, in sports situations). (Requirement #12).
- Clarification on wording of exposure of head and face and not neck. (Requirement #7)
- Confusion around Standard Requirements, some seem to contradict/negate the other.

3.2.9 Fees and Billing

Fees and Billing Response Rate

The total responses, demographics of respondents and response rate to the questions on the Fees and Billing Standard are summarized in Table 13.

Table 13 Fees and Billing Standard Response Rate for Questions	
Total responses: 288	
Demographics of Respondents: RMT: 280; Public: 4; Educator: 2; Student/Candidate: 0; Other healthcare prof: 2	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	85.62% (250 of 292 responses)
Respondents indicating the Standard is all possible to implement	93.73% (269 of 287 responses)

The results indicated that 85.62% of the respondents who provided feedback on this Standard felt it was easy to understand and 93.73% that it was possible to implement.

Fees and Billing Feedback Summary of Key Themes

The feedback provided on the Fees and Billing Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Other Colleges mention billing for ancillary services (e.g., medico legal reports, copies of records, communications, and other "non-therapy" items).
- Questions regarding assigning debt (Requirement #3), not reducing fees for prompt payment (Requirement #10) and fees not being excessive or reasonable. (Requirement #9).
- Interpretation that receipts must always have a physical/paper copy.

3.2.10 Infection Prevention and Control

Infection Prevention and Control Response Rate

The total responses, demographics of respondents and response rate to the questions on the Infection Prevention and Control Standard are summarized in Table 14.

Table 14 Infection Prevention and Control Standard Response Rate for Questions	
Total responses: 300	
Demographics of Respondents: RMT: 296; Public: 3; Educator: 1; Student/Candidate: 0; Other healthcare prof: 0	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	92.38% (279 of 302 responses)
Respondents indicating the Standard is all possible to implement	93.60% (278 of 297 responses)

This Standard had very high ratings with 92.38% of the respondents who provided feedback on this Standard felt it was easy to understand and 93.60% that it was possible to implement.

Infection Prevention and Control Feedback Summary of Key Themes

The feedback provided on the Infection Prevention and Control Standard was examined for key themes that are included in Appendix A. It should be noted that the experience of the global COVID-19 pandemic occurring at the time of the survey consultation may have had an effect on some of the feedback provided. A summary of key themes includes:

- IPAC guidelines are not always relevant for Massage Therapy practice settings.
- Define communicable disease. (Client Outcome)
- Clarify that RMTs are responsible for maintaining the practice setting not the entire practice premises. (Requirement #4)
- Clarify disinfecting expectations for equipment and laundry (e.g., requirements and frequency). (Requirement #5)
- Questions regarding hand hygiene (e.g., frequency, use of sanitizer, lack of sink at entry to facility). (Requirement #13)

3.2.11 Prevention of Sexual Abuse

Prevention of Sexual Abuse Response Rate

The total responses, demographics of respondents and response rate to the questions on the Prevention of Sexual Abuse Standard are summarized in Table 15.

Table 15 Prevention of Sexual Abuse Standard Response Rate for Questions	
Total responses: 293	
Demographics of Respondents: RMT: 285; Public: 3; Educator: 2; Student/Candidate: 2; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	84.75% (250 out of 295 responses)
Respondents indicating the Standard is all possible to implement	96.25% (282 out of 293 responses)

The results indicated that 84.75% of the respondents who provided feedback on this Standard felt it was easy to understand and 96.25% that it was possible to implement.

Prevention of Sexual Abuse Feedback Summary of Key Themes

The feedback provided on the Prevention of Sexual Abuse Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Much disagreement with not being able to provide Massage Therapy to a spouse.
- Confusion around what relationships are permitted, which are not, and how long after being a client can a relationship begin? (Requirement #2)
- Confusion about what constitutes minor/incidental/emergency care (for spouse). (Requirement #2)
- Questions about disabling audio/video devices during treatment. (Requirement #4)
- Similar issues and confusion related to written consent for sensitive areas as noted in Client-centred Care and Consent.
- Client commented that the directness/detail of the Standard makes them feel they may be at risk for sexual abuse from the RMT, "I think that the way this standard of practice reads, especially from a client standpoint, is that they are at risk for sexual abuse… if I were to read this as a client I would read it as my therapist has to actively try not to sexually abuse me as opposed to the intent of the standard which is to provide guidelines on how to best support clear communication and physical boundaries during the treatment."

3.2.12 Privacy and Confidentiality

Privacy and Confidentiality Response Rate

The total responses, demographics of respondents and response rate to the questions on the Privacy and Confident Standard are summarized in Table 16.

Table 16 Privacy and Confidentiality Standard Response Rate for Questions	
Total responses: 220	
Demographics of Respondents: RMT: 217; Public: 2; Educator: 0; Student/Candidate: 0; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	95.95% (213 of 222 responses)
Respondents indicating the Standard is all possible to implement	97.73% (215 of 220 responses)

The results indicated that 95.95% of the respondents who provided feedback on this Standard felt it was easy to understand and 97.73% that it was possible to implement. This Standard had one of the lowest response rates and highest ratings.

Privacy and Confidentiality Feedback Summary of Key Themes

The feedback provided on the Privacy and Confidentiality Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Clarify that according to PHIPA, implied consent sometimes suffices for the collection of personal health information, but not access, use or disclosure. (Requirement #4)
- Clarify the relationship between substitute decision-maker and sharing personal health information. (Requirement #5)
- Confusion between physical and personal privacy. (Requirement #9)
- Add more about maintaining confidentiality online. (Requirement #10)
- Add concept of disabling photographic/audio/video functions of device (from Professional Boundaries and Prevention of Sexual Abuse Standard).

3.2.13 Professional Boundaries

Professional Boundaries Response Rate

The total responses, demographics of respondents and response rate to the questions on the Professional Boundaries Standard are summarized in Table 17.

Table 17 Professional Boundaries Standard Response Rate for Questions	
Total responses: 264	
Demographics of Respondents: RMT: 257; Public: 4; Educator: 1; Student/Candidate: 1; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	89.02% (235 out of 264 responses)
Respondents indicating the Standard is all possible to implement	91.22% (239 out of 262 responses)

The results indicated that 89.02% of the respondents who provided feedback on this Standard felt it was easy to understand and 91.22% that it was possible to implement.

Professional Boundaries Feedback Summary of Key Themes

The feedback provided on the Professional Boundaries Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Repetition and redundancy with other Standards related to consent, sensitive areas and abuse.
- Standard is biased towards RMTs practicing in urban areas.
- Confusion around written consent for sensitive areas (Requirement #3) and disabling audio/video devices. (Requirement #4)
- Confusion around dual relationships and disagreement that RMTs should avoid treating spouse, family and friends. (Requirement #6)
- Questions about the power dynamic and why the concept is included in this Standard (Requirement #8), as well as a definition of acceptable/unacceptable gifts. (Requirement #5)

3.2.14 Safety and Risk Management

Safety and Risk Management Response Rate

The total responses, demographics of respondents and response rate to the questions on the Safety and Risk Management Standard are summarized in Table 18.

Table 18 Safety and Risk Management Standard Response Rate for Questions	
Total responses: 216	
Demographics of Respondents: RMT: 210; Public: 3; Educator: 1; Student/Candidate: 1; Other healthcare prof: 1	
Response Rate to Questions:	% (n)
Respondents indicating the Standard is all easy to understand	94.95% (207 of 208 responses)
Respondents indicating the Standard is all possible to implement	97.22% (210 of 216 responses)

The results indicated that 94.95% of the respondents who provided feedback on this Standard felt it was easy to understand and 97.22% that it was possible to implement.

Safety and Risk Management Feedback Summary of Key Themes

The feedback provided on the Safety and Risk Management Standard was examined for key themes that are included in Appendix A. A summary of key themes includes:

- Standards for IPAC and Safety and Risk Management are closely related and IPAC should be referenced in Safety and Risk Management.
- Questions about cleaning and maintenance logs. (Requirement #4)
- Unclear about the hierarchy of authority for complying with various orders and directives. (Requirement #5)
- Include information on hazardous materials compliance (unclear where to find “established protocols and practices”). (Requirement #6)

3.3 General Comments on the Standards

In terms of general comments, a total of 159 respondents provided feedback to the final question on the survey, “Is there anything else you would like to share with CMTO about the draft Standards of Practice?”

The general comments feedback was examined for key themes that are included in Appendix A. It should be noted that a considerable amount of the feedback provided by respondents in general comments was a word for word repeat of comments they had previously provided for individual Standards. A summary of key themes includes:

- Positive feedback regarding the increased clarity, comprehensiveness and relevance of the revised Standards and appreciation to CMTO for updating the Standards. There were, however, some comments that the Standards were little changed from the former ones.
- Feedback to CMTO related to topics such as terminology (e.g., RMT, Massage Therapy, patient versus client), trust to ensure that the feedback is listened to, and the (perceived) role of CMTO in protecting RMTs and setting membership fees.
- Repetition of feedback expressed in individual Standards as well as the mention of gaps related to advertising and records.
- Question why there is no reference in Standards to using an evidence-informed approach.
- Finally, once again there were many comments, previously noted in individual Standards, related to repetition throughout the Standards generally, and specifically repetition of consent and consent for sensitive areas. This may have been due to survey respondents reviewing the Standards as a complete document, instead of reading each Standard as a stand-alone document, as may be the case once the Standards are implemented.

4.0 SUMMARY OF KEY FINDINGS

4.1 Summary of Response Rate and Demographic Profile of Respondents

A total of 1624 individuals opened the survey and responded to the initial question related to type of respondent. The largest group was CMTO registrants who represented 93.41% of survey respondents and approximately 9.98% of CMTO registrants. Of note was the relatively high response rate of members of the public/clients who responded to the survey with 63 respondents, representing 3.88% of all respondents. For the most part, the characteristics the CMTO registrant respondents, in terms of primary practice setting and years of experience, generally reflected the CMTO registrant data for a similar time period.

4.2 Summary of Results

The *response rate* for each Standard varied throughout the survey and ranged from 631 (Client-centred Care) to 216 (Safety and Risk Management), with an average rate of 321. This differential could be due to certain Standards being of more interest to respondents, such as Client-centred Care. Even though respondents could select which Standards they wished to respond to, a progressively diminishing number of respondents was noted towards the end of the Standard document. This could possibly reflect an element of survey fatigue in participants, which is not unusual for a survey of this length.

The percentage of respondents who indicated that a specific Standard was *all easy to understand* ranged from 83.99% (Acupuncture) to 95.95% (Privacy and Confidentiality), with an average rating of 89%, indicating that overall, the large majority of respondents had no difficulty understanding any elements in the Standards. These findings also highlighted that five of the Standards, where only approximately 85% of respondents indicated the Standard was all easy to understand, required further consideration to identify a few specific issues which may have affected the Standard's clarity (i.e., Acupuncture, Client-centred Care, Collaboration and Professional Relationships, Fees and Billing, Prevention of Sexual Abuse).

The percentage of respondents who indicated that a specific Standard was *all easy to implement* ranged from 87.00% (Collaboration and Professional Relationships) to 97.73% (Privacy and Confidentiality), with an average rating of 93%. All of the Standards, with the exception of Collaboration and Professional Relationships, received an over 90% positive rating in terms of their ability to be implemented.

A number of *general comments* were also received and included: positive feedback on the Standards; questions about terminology; repetition of feedback received on individual standards; and comments related to repetition throughout the Standards generally, and specifically repetition of consent and consent for sensitive areas.

In *summary*, these positive findings indicated that overall, survey respondents felt Draft 2 of the Standards was clear, easy to understand and possible to implement in a broad range of practice settings. The slightly lower *all easy to understand* ratings compared to the *all easy to implement* scores may have reflected the respondents' focus on ensuring clarity on a few specific issues as mentioned earlier. The valuable feedback that was provided was useful to further enhance the clarity and applicability of the Standards.

5.0 DEVELOPMENT OF THE DRAFT FINAL STANDARDS OF PRACTICE

This report summarizes the results of the survey consultation on the CMTO Standards of Practice and highlights aspects for further consideration. The following outlines the subsequent steps to develop the Draft Final Standards.

5.1 Review by SPAG and Legal Counsel

A summary of the results of the stakeholder survey consultation, the list of key issues and Draft 3 of the Standards were presented to the SPAG at virtual meetings on December 15 and 16, 2020. SPAG members reviewed the information and provided feedback on the proposed revisions in Draft 3 of the Standards. Following the meeting, CMTO staff consolidated the SPAG feedback for each Standard, revised Draft 3 of the Standards, and updated the list of key issues. The Standards were sent to Legal Counsel for further review in December 2020.

Feedback from the survey consultation and the SPAG highlighted several issues related to the Draping Standard that required further clarification. In addition to questions about some of the wording and repetition, there was confusion around using clothing instead of draping, draping sensitive areas and treatment of the chest of males, and exceptions to reaching under draping during Massage Therapy treatment. CMTO staff worked with Legal Counsel to clarify the Requirements around these issues and the Draping Standard was revised.

5.2 Mini Consultation on the Draping Standard

In order to receive feedback on the revised Draping Standard (renamed Draping and Physical Privacy), a mini consultation was carried out with selected RMTs and Massage Therapy clients/the public. Peer Assessors of the College and the SPAG were invited to participate in an online survey from January 7, 2021 to January 13, 2021. Members of Ontario's Citizen Advisory Group, as a sample of Massage Therapy clients, were invited to participate in an online survey from January 11, 2021 to January 18, 2021. A total of 43 RMTs and 25 client representatives responded to the survey. The feedback provided on the Draping and Physical Privacy Standard was examined by CMTO staff for comments and key themes that are included in Appendix B. A summary of key themes identified for RMTs and clients includes:

Feedback from RMTs - Themes

- The majority of RMTs indicated:
    - They understood what was expected from Massage Therapy treatment regarding draping and physical privacy (86.5%).
    - The Standard appropriately balances client protection and the ability to provide effective treatment (71%). Those that disagreed indicated the Standard is likely skewed towards client protection which does not disrupt day-to-day practice.
    - There were no implementation issues (60%), however those identified included reaching under draping, continuously monitoring for change in consent, requirements for discussing options, and draping/treating sensitive areas.
- Regarding reaching under draping, a majority of respondents did not see a need to reach under, therefore recommended that CMTO remain with the current approach.
- Those indicating a need to reach under draping, cited examples that benefit clients (treatment and protection) that include:
    - clients with disabilities or positional restrictions,
    - for client safety (tight draping, remaining covered),
    - for client comfort (temperature regulation), and /or

    - to access certain body areas in different specific circumstances for effective care.
- RMTs may still choose to not reach under the draping if they are concerned about their own risk.

Feedback from Clients - Themes

- Clients strongly agreed that the Standard helped them to understand what to expect from Massage Therapy treatment regarding draping and physical privacy.
- They noted that key aspects of the Client Outcome would be met if RMTs followed the requirements of the Standard, in that it would help clients feel:
    - comfortable during treatment,
    - safe during treatment, and
    - that their body would be covered during treatment in a way that maintains boundaries.

After receiving this additional input from clients and RMTs, CMTO staff revised the Standard in consultation with Legal Counsel. The Draping and Physical Privacy Standard was presented to QAC for approval at a focused meeting on January 29, 2021.

5.3 Review by the Quality Assurance Committee

The Survey Consultation Report, the list of key issues and Draft 3 of the Standards (minus the Draping and Physical Privacy Standard) were circulated to the QAC in preparation for their meeting on January 18, 2021. At that meeting the QAC reviewed Draft 3 of the Standards and suggested a few minor revisions. The Draping and Physical Privacy Standard was then presented to the QAC at a focused meeting on January 29, 2021, along with the revised Draft 3 of the Standards. Following a careful review, the QAC approved in principle Draft 3 of the Standards to be submitted to CMTO Council for approval.

CMTO staff revised Draft 3 of the Standards based on the outcome of the QAC discussions to create the draft final Standards for presentation to the CMTO Council on February 9, 2021.

Appendix A: Survey Consultation Results – Key Themes for Each Standard and General Comments

Appendix A.1 Acupuncture Standard Comments - Key Themes	
Standard Section[6]	**Key Themes**
General	• Some parts apply to all RMTs, some only apply to RMTs performing Acupuncture (confusing). • Several respondents felt they were not qualified to comment on Acupuncture if they are not authorized to practice it. • Good, well planned, covering all aspects.
Req't 3	• Is there minimum insurance required and if so where is that detailed?
Req't 4	• Clarification of annual declaration requirements and process.
Req't 5	• Unclear language, similar to comments on #6.
Req't 6	• Is Acupuncture within Scope of Practice/maybe this should not be considered in Scope of Practice? Maybe Acupuncture should only be done by registrants of TCM, and CMTO should not regulate Acupuncture at all? Is CMTO expanding Scope of Practice for RMTs? Is Acupuncture evidence-informed?
Req't 7	• Why is consent defined each time? It is not an educational tool?
Req't 9	• Add clients not be unattended while needles are in place.
Req't 10	• Add more re skin disinfection requirement, blood risks, use of disposable needles.
Req't 11	• Why is consent needed when referring to another RMT? Does this mean termination of present MT treatment?
Related Standards	• Why do we circularly reference other Standards?
Other Points	• Why aren't accredited Acupuncture programs listed/made public? • How is Acupuncture different from TCM College allowances?

Appendix A.2 Client-Centred Care Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Not full agreement that the term "client centred care" is used correctly here (maybe "client-focused"). Perhaps change name of Standard? Client does not seem centre to Standard and outcome. Add definition of client-centred care. • No explicit mention of importance of client's input, which is a key tenant of client-centred care (consider adding). • Client relationships – if client remains a client for one year must wait one year before having a relationship, does that mean they must wait 2 years, unclear if misconduct • Preference for term "patient" instead of "client". • Add client communication, client expressing desired goals, empathy, compassion. • Informative, clear, helpful, practical, complete easy to implement.
Client Outcome	• Should be more reflective of client perspective.
Req't 1	• Define "material" risk. • Redundant, too time consuming, refer to Consent Standard.
Req't 2	• Written consent ○ Noticing change in breast massage position, confusion, examples limited.

[6] Note: For the purposes of this document, the references in the Standard Section of the tables relate to the numbering in the CMTO Standards Draft 2 version that was used for the consultation.

Appendix A.2 Client-Centred Care Standard Comments - Key Themes	
Standard Section	**Key Themes**
	○ Why are gluteal muscles mentioned only once per treatment and chest wall/inner thigh every time? Should be the same for all sensitive areas, should differ by sex/gender. ○ Makes client uncomfortable, awkward, inconvenient (reported by RMTs/clients). ○ Define precise anatomical boundaries. ○ Should written consent be required when client is fully clothed? ○ Disruptive especially if treatment plan changes during treatment. ○ Sexualizes parts of the body, difficult to remember to do. ○ Takes up too much time (RMT and client reported), there too many other things to do, unrealistic in Covid. ○ Empowers RMT not client, overwhelming to clients.
Req't 4	• Disagree every client will have a treatment plan. • Client comment – treatment plans are a waste of time, change frequently.
Req't 5	• How is practicing within Scope of Practice related to client-centred care?
Req't 14	• Discharging clients ○ What if client wants to continue, role of substitute decision-maker? ○ Sometimes clients just stop showing up. ○ Distinction between discontinuation of treatment and planned discharge. ○ Discharge of a client. There seemed to be a discrepancy with the regulation. (Acts of professional misconduct 10.4) (RMTAO)
Req't 15/16	• Redundant, covered in Sexual Abuse/Boundaries Standards – refer to Standard.
Req't 17	• Add client's written consent for transferring records. • Can RMTs charge a fee for this service? Add "…which can, at the RMT's discretion, include a fee for service."
Resources/Related Standards/CSCs	• Add link to PHIPA.
Other Points	• Parameters around client discharge and discontinuation. • Clarification around one year after ceasing to be a patient.

Appendix A.3 Collaboration and Professional Relationships Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Some requirements should only be for "formal" collaboration. • Some requirements should only be for "verified" parties. • What happens if you are the only one treating the client? • Good, easy to understand, great practice – "not everyone knows everything."
RMT/Client Outcomes	• Who are "others"? Can we add to glossary? (throughout Standard)
Req't 1	• Aligning treatment plan contentious – frustrating, insulting, lessens expertise of RMT (seems like RMT needs to follow others' treatment plans), unreasonable, concerns re use of the word "align" which is different than "collaborate", interpreted as RMT must change/yield/adapt their plan to suit other providers' plans, what if RMT disagrees with others' plans or isn't privy to it? Will this always be in the client's best interest?
Req't 2	• In b – clarify referrals – sounds like this applies to every referral the client has ever had instead of being related to the treatment plan in effect. • Add word "significant" before collaboration and professional relationships. Patients may have ongoing relationships and collaborations not pertinent to the RMT treatment plan. It ought to be within the professional judgement of the RMT on whom to include and collaborate.

Appendix A.3 Collaboration and Professional Relationships Standard Comments - Key Themes	
Standard Section	**Key Themes**
Req't 3	• Disagreement on whether consent should be explicit for sharing within circle of care or client should have the right to opt out (i.e. consent is assumed until revoked). • Add that clients should understand/consent to terms of circle of care. • Connect to Privacy and Confidentiality. • Add Consent requirements when releasing information to insurers; substitute decision-makers. • Add word "verified" to indicate that (remind) an RMT must ensure the other health care professional has been duly identified to be a person involved in the Patient's actual care.
Req't 4	• Too vague – clarify/give examples. • Asking too much of RMTs, asking them to be "mediators" or "mental health workers."
Resources/Related Standards/CSCs	• Add resource – PHIPA Circle of Care: Sharing Personal Information. https://www.ipc.on.ca/wp-content/uploads/resources/circle-of-care.pdf .

Appendix A.4 Communication Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Good, like this Standard, comfortable with wording, easy to understand.
RMT and Client Outcome	• For "accurately informed decisions" – add word accurately. • RMTs "have an obligation to create the conditions necessary for creating autonomous. choice" and to enable and "respect an individual's right to self-determination."
Req't 1	• "Meaningful choice" is critical to Informed Consent communications. • Suggestions to add: client interview, "supportive and open dialogue to ensure they are given the opportunity to discuss their goals, make changes to their treatment, raise concerns, or ask questions", cultural sensitivity, substitute decision-maker. • Redundant to outline criteria of consent, rather refer to Consent Standard. ○ Consider making this Standard subpoints within the Consent Standard.
Req't 2	• RMTs are not trained in active listening or plain language skills.

Req't 3	• Adapt communication
	  ○ Want examples.
	  ○ Suggest: "strive to…"
	  ○ "Adapt communication according to Patients' understanding and needs. The RMT must permit a third party, when necessary, to be present in the treatment room to assist with communication, especially for the following populations who may have difficulty effectively communicating their goals: a) disabled, or, other abled persons, b) children or seniors who have limited speech, c) people whose first languages are not English or French, d) trauma or mental health impacted patients."
	• #3 is covered within #2.
	• The RMT can request the third party also be enrolled into a secure and confidential communication by providing documentation that can be signed for the Treatment Plan.

Req't 4	• Unsure how to apply #4 to public media (e.g. Facebook).

Appendix A.5 Conflict of Interest Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• The requirements only cover financial conflicts. • Lots of general confusion over what the requirements mean. • RMTs are always in conflict of interest by nature of being paid for their services. • Selling product is always conflict of interest because earning income.

Appendix A.5 Conflict of Interest Standard Comments - Key Themes	
Standard Section	**Key Themes**
	○ Should not have to disclose other options because it is part of business model. • Written in the negative (unless other Standards). • Dual relationships/treating family and friends should be permitted. • Connect to concepts of integrity, ethical behaviour. • Is referring to providers within same clinic conflict of interest? • Good job of communicating confusing concept, all areas covered, good to have this Standard.
Req't 1	• Referral fees ○ Are they always conflict of interest? (e.g., spend time finding good fit with another RMT if they are too busy to take a new patient) ○ Is this not a legitimate form of advertising?
Req't 2	• Disclosure of conflict of interest to client not always necessary. • Documenting in health record not necessary.
Req't 3	• Revenue sharing ○ Some not sure what this requirement means/examples please. ○ How does this work if owner is not a regulated health professional? ○ More reflective of RMT business agreements: "When RMT is in a practice setting that revenues are shared among the organization as a whole, the RMT must ensure that a written agreement is in place that ensure the RMT is still held responsible for the professional aspects of their practice." ○ Another suggestion: "If you have a percentage split, make sure you have a contract stating that you are responsible for the professional aspects of the practice." • Confusion that "sharing fees" may be about disclosing how much money one has.
Req't 4	• Rental agreement ○ How would this be interpreted if a Chiropractor or Physiotherapist is the landlord? Would this be an issue? (RMTAO) ○ Examples please. ○ Is rent, or % of fees in lieu of rent/split, always conflict of interest? The way it is written, it seem so, but this is the business model for many RMTs. ○ Does this mean landlord cannot also be client?

Appendix A.6 Consent Standard Comments - Key Themes	
Standard Section	**Key Themes**
Client Outcome	• Suggestion change to: "The client receives evidence-based, best-practice information they need to make an autonomous decision... "
Req't 1	• Confusion around billing if treatment stopped.
Req't 3	• Noticing CMTO's change in stance on breast massage, confusion. • Written consent ○ What are written consent requirements for digital signatures? ○ Anatomical boundaries required to understand how to meet this requirement, clients have different sensitive areas, breast examples limiting. ○ Unnecessary, redundant, awkward, why not once per treatment plan? ○ Why do other HCPs not have to do this? ○ How does this work with substitute decision-makers? ○ COVID-19 IPAC requirements add barrier to safely implementing.

Appendix A.6 Consent Standard Comments - Key Themes	
Standard Section	**Key Themes**
	○ Not all assessment is done before beginning treatment, not implementable to stop part way through treatment to get written consent to proceed. ○ Written consent will not eliminate sexual abuse, does not protect the patient (explanation/conversation part needed too). ○ Requests to remove written consent requirement. ○ Clients think it benefits RMT not themselves. ○ Patient should list any body part they do not want touched – more inclusive.
Req't 5	• Add in link to Health Care Consent Act with reference to capacity. • How is one's capacity to consent determined? (expansion pack list). • How do you verify that someone is a substitute decision-maker? (expansion pack list)
Req't 6	• Confusion around monitoring/verifying consent – what does this mean exactly? • Change to: "The RMT must ensure patient empowerment with ongoing verbal consent throughout assessment and treatment."
Req't 7	• Unclear, more clarification around what is needed.
Other Points	• If consent is revoked and treatment is stopped, what does that mean for billing/charging? • Guidelines to determine capacity to give consent, what is true meaning of incapable, what about age, verification of substitute decision-maker? • Information around documenting consent in terms of capable, substitute decision-maker. • How does this work with electronic health record?

Appendix A.7 Draping Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Some situations the Standard may not apply to: sex/gender (some men do not feel chest/breast/nipple are sensitive areas), does not acknowledge that some clients are treated while clothed, client wearing shorts, therefore legs always undraped, only undraping areas that are being treated doesn't apply to corporate settings, providing massage during labor, genitals will be exposed, with sports (athletes, runners, swimmers) the physical boundaries are often whatever clothing or sportswear they are wearing. • Body areas ○ Please explain the actual anatomical boundaries, what is gluteal cleft? ○ Client may feel other areas are "sensitive areas" (e.g., abdomen). ○ What are the areas that should never be undraped? ○ Do men need to sign written consent to leave their chest undraped? • Sports related environments want exception for reaching under draping. • Should state clothing can be used instead of draping, many clients treated in clothing. • Draping standard is inconsistent with the other standards in that it is very narrow in focus, and detailed. • All requirements for draping covered. • Exceptions should be stated – e.g., at swim meet, with clothing on – important for specific populations who don't want to or cannot disrobe. • Not client-centred in approach. • Add: "When draping is not utilized" or "In circumstances where an RMT does not use draping the RMT must:"
RMT Outcome	• "Privacy" used in a way that doesn't match glossary definition.
Client Outcome	• Add concept of client safety (maybe in Client Outcome).
Req't 1	• Unclear how this is related (what are the risks of draping that the RMT is expected to communicate?)

Appendix A.7 Draping Standard Comments - Key Themes	
Standard Section	**Key Themes**
	• Redundant, why is it in so many Standards? Not required. Reference Consent Standard. • Not client-centred.
Req't 2	• Add in that client can choose to remain clothed in addition to draping? In lieu of draping? With requirements? • Should include conversation about gauging client's comfort/get their input with proposed draping (client-centred).
Req't 4	• Add that clothing can be used instead of draping. • Add wording to indicate that there is an "in-between" option between draping and fully clothed.
Req't 5	• Do we need to get consent every time we undrape anything? • Sounds excessive and disruptive.
Req't 6	• Sometimes the area not being treated needs to be exposed (e.g., leg exposed, and gluteus muscle covered for treatment of gluteus over sheet).
Req't 7	• Clarification on the wording- What about the neck? (RMTAO) • Not client-centred, doesn't work if client remains clothed, impractical. • Draping should not be transparent (e.g., threadbare).
Req't 8	• Not client-centred. • Implementation issue: Draping exposes various part of the body (e.g., calf exposed when undraping thigh, arm exposed when shoulder undraped). (#7, #8) • For hearing impaired clients, it is important to use both visual and tactile cues when changing the drape.
Req't 10	• #7/8 and #10 seem to contradict/negate one another (only undrape certain areas… unless client requests certain areas). • What if a man wants his chest exposed for temperature regulation? • What is "actively accessing or treating? E.g., if needles in lower body area and manual therapy on upper body?"
Req't 11	• Add "with the exception of working with another professional in the specific situation where it cannot be avoided, such as a delivery room."
Req't 12	• Reaching under draping: must reach under client (and therefore under draping) to treat back of person who can only lie on their back, must reach under when rib raking of a female client in order to access the serratus anterior in a side lying position could potentially expose a sensitive area not being treated. • Remove "never." • In some circumstances it is better to actually reach under a drape to maintain a barrier in place to prevent exposure of a sensitive area. • Add that if situation happens accidentally should be documented in client file. • Disagreement on whether this requirement works (some pro some con). • Assumes all clients treated unclothed.
Other Points	• Detailed information regarding specifics of draping, clothes on or off, especially related to sports Massage Therapy e.g., use of videos.

Appendix A.8 Fees and Billing Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Very good, clearer than before. • Other Colleges mention billing for ancillary items (e.g., medico legal reports, copies of records, communications, and other "non-therapy" items).

Appendix A.8 Fees and Billing Standard Comments - Key Themes	
Standard Section	**Key Themes**
RMT Outcome	• Who determines "fair and equitable" when insurers set expected rates.
Req't 1	• Unclear how to meet requirement of copy of receipt: o Physical copy, or just record of how they paid? o Must be paper? Wasteful. • Misinterpretation that all receipts must be paper.
Req't 3	• "Assigning debt" o Excludes insurers. o Disallows RMTs from collecting payment, think this should be allowed. o Suggest collection agency should be permitted after reasonable attempt made, not disclose any personal health information, and notify client. o Reimbursement for MVAs. o Other professions allowed to send debt to collections. o Seems more about optics than public protection. o If the business is permitted to assign debt, how does that work?
Req't 8	• Regulation says that you can increase your fee with prior consent. It also states that you can decrease a fee with a notation in the file. (Acts of professional misconduct 8. 33 + 34). Could you provide clarity on this? (RMTAO)
Req't 9	• Criteria for excessive or unreasonable? • Subjective wording – reword for clarity.
Req't 10	• Not reducing fees for prompt payment: o Not equitable. o Does not protect the public. o Don't know from legislation. o Business interference.
Req't 11	• Why are transaction and RMT name in the same line? • Receipts should also be allowed to say "Registered Massage Therapy" (not just Massage Therapy). • Why are signatures still required (outdated, often direct billing, does this include e-signatures). • Suggest linking to CRA to keep requirements evergreen (applies to 12 and 13 as well).
Req't 13	• Gift certificates and insurance (issue date vs treatment date, $ value vs what was redeemed). • Provide example of gift certificate .

Appendix A.9 Infection Prevention and Control Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Many IPAC guidelines and training is not relevant for MT. o Many IPAC guidelines and training is not transferable to different MT practice settings (usually tailored to hospitals). o Should only be held to those what are within Scope. o CMTO should translate relevant training and government docs to be applicable to MT practice setting(s). o Consult with the Chief Medical Officer, and other Manual Therapy Colleges (ex: Physiotherapists and Chiropractors) to refine how we interpret the IPAC guideline, review based on what is in Scope of Practice. • Cleaning logs should not be required (RMT knows what they cleaned). • Too specific in some places ("micromanagement"). • Clarify that this Standard is in addition (/"above and beyond") the Safety and Risk Management one.

Appendix A.9 Infection Prevention and Control Standard Comments - Key Themes	
Standard Section	**Key Themes**
	• Not all clients get treatment plans. • Suggestions to add: RMT nail requirements, disinfection topical bottles/dispensers, use of heat (thermaphores), can ask clients to don PPE to protect other clients, extra acupuncture modalities, equipment must be in good repair (in order to be cleaned effectively).
Client Outcome	• What is a communicable disease?
Req't 4	• Suggest RMT responsible to maintaining "treatment area" or "practice setting" not "practice premises" as it is not always their responsibility (e.g., at a gym or sports field) and it is not always clear what practice premises means.
Req't 5	• Laundry o Details of requirements wanted. o Concern that it not necessary for MT. o What does it mean to disinfect linen. o Can't always follow PHO when requirements are unreasonable, like cleaning and disinfecting linens (e.g., feasibility of PHO/IPAC recommendations such as use of negative-pressure laundromats and commercial washing machines).
Req't 6	• The glossary link to "risk assessment" goes to PIDAC's "Routine Practices and Additional Precautions in All Health Care Settings". This document was last revised in Nov 2012 and is therefore not up to date considering recent events and is heavily geared towards full medical practice settings.
Req't 7	• No disagreement to postpone treatment if IPAC can not be implemented.
Req't 8	Questions about providing info to clients: o Provide info about PPE or provide PPE? o What info should be provided?
Req't 9	• Required to notify PHO of failure to maintain IPAC practices?
Req'ts 10-12	• Define "regularly" for routine practices. o Suggest: "at least monthly/quarterly", or "The RMT must select an appropriate schedule for maintaining IPAC practices in accordance with their practice setting and schedule." • Risk assessment o Don't know how to interpret (e.g. what is acceptable level of risk). o Use more up-to-date reference. o Use reference more reflective of MT practice. o Add requirement to document.
Req't 13	• Handwashing requirements seem excessive: o Frequency. o To the elbow every time. o Duration. o Water and soap not available in all settings (e.g. sporting events). o Sanitizer should be permitted. o Many settings do not have a sink at entry to facility. o Waste of time/resources.

Appendix A.10 Prevention of Sexual Abuse Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Consider adding that it's mandatory to post in treatment/clinic spaces that the client can report to the CMTO if they have been sexually/physically abused by an RMT.

Appendix A.10 Prevention of Sexual Abuse Standard Comments - Key Themes	
Standard Section	**Key Themes**
	• Detail different therapeutic relationships and whether they are permitted or not, and why (e.g., RMT and spouse, RMT and RMT who is spouse, RMT and friend….) • No information around colleagues and other RMTs. • Content makes clients feel they are at risk for sexual abuse from RMT.
Req't 2	• Sexual relationships with clients: o If a person is a client for one year after treatment, and the RMT must wait a minimum of one year, is that two years in total? o Whether it would be professional misconduct is vague. • Treating a spouse: o Should not be sexual abuse (CMTO should change the requirement). o What constitutes treatment? e.g., not charging a fee? o Impractical during pandemic, vague. o RMTs know how to treat spouse and remain professional. • What constitutes minor/incidental/emergency care? o This contradicts current Zero Tolerance policy, confusing. (RMTAO) o Some found the explanation provided helpful.
Req't 4	• How do you disable audio if music is played during treatment? More details on what this requirement is (e.g., must shut down device?).
Req't 6	• Consider adding that the RMT may discontinue treatment if a client initiates inappropriate or sexual touching, or a desire to initiate a sexual relationship.
Req't 11	• Written consent for sensitive areas: o It's confusing that breasts and gluteal muscles are both sensitive areas but managed differently. o Noticing change in breast massage position, confusion. o Takes away "RMTs professional judgement and the client's autonomy." o How does it work with substitute decision-makers? o Suggest having client list any body part they do not wish to be treated.
Req't 12	• Suggest adding a reference to how treatment could be provided over clothed areas.
Other Points	• Education around Massage Therapy to spouse and exceptions to treatment of spouse. • What are the precise time limits around dating a previous client? • More information on disabling an audio/video/photo device.

Appendix A.11 Privacy and Confidentiality Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Disabling audio/video (from Boundaries and Sexual Abuse) relevant here. • Doesn't address the issues that arise when the clinic owns client files, not the RMT. • Fine, everything is covered, very good.
Req't 4	• 'Obtain consent to collect' PHIPA doesn't require consent to collect (ie. Health history form it is given back without asking, as consent is implied), the use of the information on the health history form would require consent. (RMTAO) • Express vs. written consent for disclosure confusion. (Req't 12 as well) • Be more clear about within or out of circle of care. • Define "express consent."
Req't 5	• Consent/capable/substitute decision-maker – connection to privacy & confidentiality not clear.
Req't 6	• Add that it is not a breach to allow a peer assessor to review files.
Req't 9	• Privacy required during intake (not clearly stated).

Appendix A.11 Privacy and Confidentiality Standard Comments - Key Themes	
Standard Section	**Key Themes**
	• Requirement #9 may be a different interpretation of "privacy" than the rest of the Standard/glossary.
Req't 10	• Add maintaining confidentiality online (app permission, online testimonials). • Clarify about client access to record.
Resources/Related Standards/CSCs	• Add Circle of Care document from the Privacy and Information Commissioner of Ontario https://www.ipc.on.ca/wp-content/uploads/resources/circle-of-care.pdf . Very useful, relevant, and practitioner oriented with respect to how we share information and with whom.

Appendix A.12 Professional Boundaries Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Repetition, redundancy. • Well written, detailed, complete, specific. • Biased to RMTs that practice in large urban centres and towns, does not consider those practicing in rural areas.
Req't 2	• Define 'material' risk.

Req't 3	• Written consent:
	  ○ Seems to benefit RMT not client.
	  ○ Waste of time - Should be once per treatment.

Req't 4	• Requirements for disabling devices (e.g., turn off function? Power down?) Smart devices that 'passively' listen/use microphone?
Req't 5	• Define significant value, seems subjective.

Req't 6	• Dual relationships:
	  ○ Confusion how dual relationships is "avoid" but spouse is abuse.
	  ○ Disagree with spouse, family and friends should be avoided.
	  ○ Exception for small towns, family in need, pandemic.
	  ○ Limits client's freedom/right to choose their provider.
	  ○ Add exceptions for when you don't have to avoid a dual relationship.
	• Add "a written declaration of professional boundaries" be included in any treatment plan.
	• Include exceptions from Sexual Abuse.

Req't 8	• Be more clear on power dynamic and why included here.

Other Points	• More information related to:
	  ○ Power dynamic in therapeutic relationship.
	  ○ Professional boundaries and relationships/dual relationships.
	  ○ How to disable devices.
	  ○ Acceptable/unacceptable gifts and gifts of significant value.

Appendix A.13 Safety and Risk Management Standard Comments - Key Themes	
Standard Section	**Key Themes**
General	• Redundant to IPAC Standard. • Reference IPAC in requirements. • Good, all aspects covered.
Req'ts 3 & 10	• "Privacy" not used in way consistent with Glossary definition.

Req't 4	• Cleaning and maintenance log:
	  ○ Detail what to include/Want an example or template.
	  ○ Too burdensome to document everything between every client.
	  ○ Not always done by the RMT (e.g. in a gym setting).
	  ○ Should this be mandatory that it's visible to public?

Appendix A.13 Safety and Risk Management Standard Comments - Key Themes	
Standard Section	**Key Themes**
	○ Special log for cleaning bathrooms?
Req't 5	• Want to know the hierarchy of authority (not to follow the most restrictive requirements).
Req't 6	• Unclear where to find "established protocols and practices for hazardous materials compliance."
Req't 7	• Courses/training/certification: ○ Want examples. ○ Want instructions on how to identify the need. • First Aid/CPR certification/maintenance should be required.
Req't 9	• Examples of safety incidents.
Resources/Related Standards/CSCs	• Hyperlink to Draping Standard broken. • Connection to Draping unclear.

Appendix A.14 General Comments - Key Themes	
Broad Themes	**Specific Key Themes**
Positive Feedback for Revised Standards	• Appreciate access to supporting documents such as Resources, Career Span Competencies. • Appreciation expressed to CMTO for updating Standards. • Consistent in approach one-to-another, clearly written. strongly outcome based, relate well to public safety, very appropriate and meaningful listing that RMTs should understand and be able to apply. • Increased clarity of language, concise and easy to understand. • More focused and specific, easy to implement. • New direction, well laid out, thorough.
Neutral/negative Feedback	• Little change from previous standards. • Reworking, repetition of previous Standards. • Too much information, too wordy, too complicated and burdensome.
Feedback for CMTO	• Change "client' to 'patient'. • CMTO and Standards should protect RMTs as well as clients. • Compliance with Standards – what happens to violators? Should be contracts with employers for compliance. • Reduce membership fees and set fees for Massage Therapy. • Suggested changes to RMT title, 'Massage Therapy', Scope of Practice. • Trust to ensure feedback is listened to on Standards. • What is happening with the Technique Standards?
General	• Comments related to survey format. • Consider true meaning of client outcome. • Editorial suggestions including benefit/limitations of hyperlinks. • No standard on Advertising – enforcement of no testimonials, professional conduct on social media. • No standard on record keeping, treatment notes, retention of files. • No reference to evidence-informed approach. • Repetition of comments re specific Standards (already captured under appropriate Standard): Acupuncture, Client-Centred Care, combine Communication and Consent, Communication, Consent, Fees and Billing, Infection Prevention and Control, Prevention of Sexual Abuse. • Should be higher standards for home practice.

Appendix A.14 General Comments - Key Themes	
Broad Themes	**Specific Key Themes**
Repetition Throughout Standards	• Repetition of same information in multiple Standards. • Should be more concise, could be streamlined. • Too much redundancy, repetition, unnecessary Standards.
Repetition of Consent	• Consent repeated in full many times. • Repetition confusing and frustrating. • Unnecessary, other Standards are not represented in this way.
Consent Related to Sensitive Areas	• Issues regarding obtaining consent for treatment of gluteal region. • Issues with specific examples related to breast massage. • Question need to seek written informed consent prior to every treatment of sensitive areas .

Appendix B: Mini Consultation Results – Key Themes for Draping and Physical Privacy Standard

Appendix B.1 Draping and Physical Privacy Standard RMT Comments - Key Themes	
Standard Section	**Key Themes**
General	• Generally reported understanding what is expected regarding draping and physical privacy. • 71% reported the Standard appropriately balances client protection and the ability to provide effective treatment. Among those that disagreed, there was acknowledgement that it is likely skewed towards client protection, does not disrupt day-to-day practice, and only feels too prescriptive for long-standing therapeutic relationships. • 60% reported no implementation issues. Implementation issues were focused on reaching under the draping, continuously monitoring for change in consent, requirements for discussing options, and draping/treating sensitive areas.
Req't 2 (and general)	• Client should have option to remain clothed even if their clothing isn't ideal for treatment.
Req't 4 (and general)	• Some RMTs do not have the "tools" to offer treatment through clothing – would they have to refer to another RMT because they can't provide options?
Req't 6	• Wording is unclear (the grammar is difficult to follow).
Req't 7	• It is risky to allow reaching under the draping (cannot see hands, can make clients uncomfortable, not part of practice), some think treating over the draping should be the alternative and listed separately? Reaching under draping: • Recommendation from some RMTs: remain with the current approach. • A higher number of respondents (62%) do not see a need to reach under the draping, justifying this position as the base requirement. • Among those that do see a need to reach under (38%), some compelling examples of circumstances that benefit the client (treatment and protection) include: o For clients with disabilities or positional restrictions. o For client safety (tight draping, remaining covered). o For client comfort (temperature regulation). o To access certain body areas in different specific circumstances for effective care. • RMTs may still choose to not reach under if they are concerned about their own risk (client risk is covered in the requirement). • Consideration of additional risk for sexual abuse: o The current wording does create increased potential of accidental boundary crossing and does put more onus on the RMT to make decisions regarding when this risk is appropriate and how to mitigate it. o It seems unlikely that this would increase risk regarding predatory behaviour as this touch is non-consensual, however, it may make it more challenging to discipline when arguing over evidence on consent to touch.
Req't 9	• Unclear why other options need to be discussed if above requirements are followed, and what those other options would be.
Req't 11	• Unclear that the requirement is to continuously monitor for change.
Req't 12	• Confusing/misleading to say that draping creates physical boundaries when treating over the draping is permitted.
Req't 13	• In practice, arms can be exposed when treating shoulder, so "arm" should be included on the list of exceptions. • What is the meaningful difference between #13 and #14?
Consider adding	• Requirements for draping (basics): size, material, washability, threadbare/transparency.

Appendix B.1 Draping and Physical Privacy Standard RMT Comments - Key Themes	
Standard Section	**Key Themes**
	• Offering assistance, instructing client to move/adjust and caution adjusting draping accordingly. • Infants and lack of draping. • Gluteal cleft/genital area is mentioned only about not exposing, not about not touching (not directed related to Draping but high risk).

Appendix B.2 Draping and Physical Privacy Standard Client Comments - Key Themes	
Standard Section	**Key Themes**
General	• 100% of respondents agree or strongly agree that they understand what to expect from Massage Therapy treatment regarding draping and physical privacy. • General agreement that the key aspects of the Client Outcome would be met if RMTs followed the requirements of the Standard, in that it would help clients feel: o comfortable during treatment, o safe during treatment, and o that their body would be covered during treatment in a way that maintains boundaries.
Suggestions to add	• Types of draping that are permitted/client can expect to be offered. • What constitutes appropriate draping (opaque, size). • Clarify that informed consent is obtained via discussion. • RMT should have to discuss pain tolerance with client. • Managing language, culture diversity. • RMT and client should both sign a written agreement acknowledging that they had a discussion about consent and boundaries (copy for both RMT and client).
Other key themes	• Helps establish boundaries, trust, respect. • These are the procedures that need to be followed to protect the client. • Covers all aspects of safety, privacy, comfort, communication. • Covers any concerns/issues I had. • Will be helpful for clients. • I feel most comfortable when exposure is minimized. • Clear when draping is required. • Clear what consent is required and when. • Extremely client centred which is important. • Thorough. • Easy to understand, easy to understand if English is first language, clearly written. • It's important to have a Standard on Draping like this that sets clear expectations for both RMTs and clients. • Standards like these helps the most vulnerable feel safe and seek treatment. • RMTs should spend more time discussing health goals with client at beginning of session. • Unclear on frequency for written consent/consent (possible misinterpretation that is annual, question asking if it needs to be communicated at every treatment). • Unlikely that RMTs will reverify consent prior to undraping an area of the body.