Medication Options for Severe Agitation in Delirium

Clinical Situation	Option	Typical Starting Dose in an Older Adult	Practical Cautions
Severe agitation or paranoia interfering with essential care; patient can take oral medication	Haloperidol PO	0.5–1 mg PO once; repeat only if needed	Useful when rapid calming is needed without much sedation. Check QT/electrolytes and EPS risk. Avoid in Parkinson's disease or suspected Lewy body dementia.
Severe agitation; patient refuses pills but is imminently unsafe	Haloperidol IM	0.5–1 mg IM once; repeat only if needed and per local policy	Use for short-term behavioral control when oral medication is not possible. Avoid standing orders without reassessment.
Agitation with prominent paranoia or distress; patient can take oral medication	Olanzapine PO/ODT	2.5–5 mg PO/ODT once	Helpful when both calming and antipsychotic effects are needed. Watch for sedation and orthostasis.
Sleep-wake reversal or nighttime agitation; patient can take oral medication	• Quetiapine PO • Trazodone PO	• 12.5–25 mg QHS • 25–50 mg, 12.5 mg if frail	Helpful when Parkinson's disease or Lewy body dementia is a concern. Monitor for orthostasis and fall risk. Slower onset; not ideal for immediate dangerous agitation.
High delirium risk or sleep-wake disruption; patient can take oral medication and does not need acute sedation	• Ramelteon PO • Melatonin PO	• 8 mg QHS • 1–3 mg QHS, up to 5 mg	May support circadian regulation; preliminary data suggest it may help prevent delirium. Not a treatment for established delirium or acute dangerous agitation.
Alcohol or sedative-hypnotic withdrawal, catatonia, or seizure-related agitation	Lorazepam PO/IV/IM	0.5–1 mg; route based on urgency and medical status	Appropriate for withdrawal or suspected catatonia. Avoid reflexive use in most delirium, as it can worsen confusion, disinhibition, falls, respiratory suppression, and aspiration risk.
Hypoactive delirium	No routine sedating medication	n/a	Focus on causes, mobilization, sensory aids, hydration, sleep-wake cues, and medication cleanup. Sedating medications can worsen hypoarousal and immobility.

Note: These are starting-dose ranges, not standing regimens. Document the target symptom, reassess daily, and stop the medication as soon as the safety risk or interference with medical care resolves.

From the article:
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